Supreme Court, U.S.
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No. _____

IN THE

Supreme Court Of The United States

OCTOBER TERM, 1996

Michael Leroy Dolihite, individually and as father and next friend of David Michael Dolihite, and Joyce Mary Dolihite, individually,

Petitioners,

vs.

Royce King, et al.,

Respondents.

SUPPLEMENTAL APPENDIX TO THE PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

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SUPREME COURT, U.S.

APPENDIX H

Michael Leroy DOLIHITE, individually and as father and next friend of David Michael Dolihite; Joyce Mary Dolihite, Plaintiffs,

v.

Mary Fay VIDEON, as Executrix of the Estate of Robert Maughon, deceased; Royce G. King; R. Emmett Poundstone, III; Anthony R. Dykes; Bradley Mazick; Karen Jurls; Andrew McBride; Neuropsychiatry Associates, P.C.; Chester Jenkins; Medical Money Management, Inc., Defendants.

Civ. A. No. 92-H-1398-N.
United States District Court,
M.D. Alabama, N.D.

[Filed March 21, 1994.]

MEMORANDUM OPINION

HOBBS, District Judge.

Plaintiffs have brought this civil rights action pursuant to 42 U.S.C. Sec. 1983 to redress alleged violations of plaintiffs' constitutional rights. Pendent state claims, grounded in theories of negligence, wantonness, and respondeat superior, are also at issue. The court has jurisdiction over plaintiffs' federal claims under 28 U.S.C. Secs. 1331 and 1343, and over the state claims under the doctrine of supplemental jurisdiction.

All defendants have filed motions for summary judgment[1] on the basis of qualified and substantive immunity. The issues having been briefed by the parties, the matter is now before the court. For the reasons set forth below, the court concludes that the motions should be denied as to the federal claims, but granted as to the state claims.

I. FACTUAL BACKGROUND

At this stage of the proceedings, the facts, and all reasonable inferences to be drawn from those facts, are construed in the light most favorable to plaintiffs. *Swint v. City of Wadley*, 5 F.3d 1435, 1439 (11th Cir.1993). The following findings, therefore, do not necessarily describe the circumstances with accuracy.

On February 17, 1991, the Baldwin County Juvenile Court ordered David Dolihite to Eufaula Adolescent Center as a result of problems displayed in school and home behavior. At the time of said determination, the child had no juvenile convictions on his record and no history of drug or alcohol abuse.

Upon his arrival at Eufaula Adolescent Center, on January 13, 1992, David age 15, was assessed and evaluated by defendants Dr. Maughon, a psychiatrist, Dr. Mazick, a psychologist, Karen Jurls, a social worker, Andrew McBride, a psychologist, and others. During these assessments, it was reported that David had made prior suicide attempts, gestures, and was known to have frequent suicidal ideations. It was also noted that David's grandmother had committed suicide. (Medical record of David Dolihite of January 22, 1992.) David was also inter-

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[1]Defendant Medical Money Management, Inc. has not filed a separate motion for summary judgment, but did orally represent to the court that its interests were congruent with those of defendant Drs. Jenkins and Maughon. The court evaluates Medical Money Management's liability in this light.

viewed by Andrew McBride on January 23, 1992. McBride, a psychologist at Eufaula, noted that David had suffered from problems with sleeping, suicidal ideations, and that David had made several suicidal gestures, and experienced homicidal ideations. (Medical records dated January 23, 1992.)

Dr. Maughon noted in his psychiatric evaluation of David that there was an obsession of writing poetry with themes of death. David had threatened suicide in March of 1991 by giving a poem to his former girl friend describing his death. He stated that he felt suicidal when he became angry. (Medical records dated January 23, 1992.) On January 23, 1992, ten days after David's arrival, the Eufaula Adolescent Center master treatment plan was entered into David's record. This master treatment plan was signed by Dr. Jenkins, a psychiatrist, McBride, Jurls, and others. (Medical Records of David Dolihite.) The treatment plan for these and other problems exhibited by David stated that David was supposed to be involved in a thirty minute individual therapy session once weekly, and one forty-five minute weekly group session. (Medical records of David Dolihite.)

On January 26, 1992, David was placed on continuous observation status because of his suicidal remarks. On February 4, 1992, David injured his left wrist through self-mutilation. On February 4, 1992, it was noted by defendant Jurls that David presents as extremely "irrational" regarding his thought processes. On February 14, 1992, David was assigned to work restriction and two days dorm restriction for "writing on a security screen." What David wrote on that security screen was "Oh God, Oh God, I want to die. Death. Suicide are the facts of life." (Medical records.) No suicide assessment was initiated as a result of this conduct nor was David seen, concerning this incident, by a psychologist or psychiatrist.

On February 15, 1992, David was placed in seclusion for being a "threat" to the community group. David was secluded on many occasions which included seclusion in "Building 112." (Affidavit of John Fowler, and Statement of Allen Forte). This building is located across the compound from the dormitory, and it separates the patient from all the other patients. The patients are put in one of three "cells" located in a narrow corridor. The cell doors are painted black. The cells are approximately nine feet long and six feet wide with a grate over the top of the cells with a light hanging through the steel grate. There is a two by four which goes across the door and is fixed into two U bolts. The building is not heated and the children must sit on a cold concrete floor while in the cell. (Affidavit of John Fowler and Statement of Allen Forte.) On October 31, 1990, Dr. Robert L. Okin, chairman of the Wyatt consultant committee, relayed the concerns of the committee that the use of restraint and seciusion was being inappropriately administered at Eufaula. See also PEx. 11, Annual Advocacy Report of Kathy Sawyer; PEx. 5, Wyatt Committee Report.

On February 18, 1992 at 12:40, it was noted in the nursing flow sheet that David was talking to himself. He told the nurse he was "talking to his friend who told him what to do." (Medical records of David Dolihite). On March 2, 1992, it was noted that David continued to enjoy the "shock value" of talking about suicide. On March 3, 1992, David attempted to escape from Eufaula Adolescent Center. For this he was put into "time out" for eight hours.

At 3:00 p.m. on March 8, 1992, David intentionally cut his left arm severely and was sent to the emergency room for sutures. He stated that he was going to kill himself, that he was not going to have sutures put in, and that he would remove them if they were. On this same date, Dr. Jenkins, a consulting psychiatrist, was notified about

David's having pulled his sutures out of his arm and his wanting to commit suicide. Dr. Jenkins did not see David, but instead simply ordered medication over the phone. Defendant Jenkins also, again without seeing David, authorized "soft restraints" to be used on him. At 5:10 p.m. on March 8, 1992, defendant Jurls was notified about David's suicide threats and his attempt to remove sutures from his arm. David was thereupon put into restraints. David's acts of cutting himself and pulling out his sutures were determined to be a suicidal gesture. David was never seen either by Dr. Jenkins or by Dr. Maughon as a result of this suicidal gesture; nor was he seen by the clinical psychologist on staff, Dr. Mazick.

On March 15, 1992, David was secluded for failure to follow the rules, bleeding on the walls, and defecating on the floor of the "time out" room. Neither defendant Dr. Jenkins nor defendant Dr. Maughon nor defendant Dr. Mazick saw David even after this extreme behavior.

As of March 17, 1992, David was still on close observation status due to his suicidal acts and self-destructive behavior. On March 18, 1992, David was again taken to Lakeview Community Hospital Emergency Room after sticking a pencil in his arm. At that point in time, Dr. Nixon who had seen David several times and was responsible for his health care, stated that David MUST be evaluated for antipsychotic medication. (Emphasis in the doctor's original note.)

On March 19, 1992, defendant Dr. Maughon saw David and stated that "this young man has been engaging in self-destructive behavior," and that his difficulty seems to be "behavioral." No medication was prescribed and no further assessment was conducted.

On March 21, 1992, David was again placed in seclusion. At this time it is noted that he was beating and banging his head on the wall and cursing loudly. Defendant Dr. Maughon was notified about David's beating

and banging his head on the walls and that he was "cursing and totally out of control." Dr. Maughon did not see David, nor did he ask defendant Mazick to see David.

On March 22, 1992, David was restricted to the time out room. Allen Forte was the mental health worker who placed David in time out. David's time out, according to the records, started at 9:30 a.m. Mr. Forte states on David's time out sheet that David was running in and out of the time out room at 9:30 a.m. (Attachment to Statement of Allen Forte.) At 9:35 a.m., Mr. Forte states that David was "trying to hang himself." At 9:40 a.m., Mr. Forte had David secluded. At the time he was secluded, Forte took David's shirt and belt. Mr. Forte stated that when children are placed in seclusion, mental health workers do not take their shirts unless they are trying to bring bodily harm to themselves. (Page 8, Statement of Forte.) When asked if there was any question in Mr. Forte's mind as to whether David was trying to hang himself, Mr. Forte stated that "Every fifteen minutes we have to do a check. He was in there, and I had to check him every fifteen minutes so I knew who was in there and I knew what was going on." (Statement of Forte.)

John Fowler told Karen Jurls the following day that David had tried to hang himself. (Affidavit of Fowler.) It was also noted on March 23, 1992, in David's progress notes, that he was secluded for threatening to do harm to himself. (Medical records of David Dolihite.) On March 24, 1992, at 10:00 a.m., Ms. Jurls noted that the treatment team had decided that David should serve three days dorm restriction due to his disruptive behavior. This note is directly under the March 23, 1992 note indicating that David had threatened to harm himself on March 22, 1992 and had to be secluded. However, on March 24, 1992, at 1:00 p.m., according to the records, Ms. Jurls allowed David off "close observation." Shortly thereafter there is an entry in his record by defendant Mazick, the

first such entry since David's arrival some two months previously. This entry indicates that defendant Mazick told David that "he had not engaged in the self-injurious acts for several days and it was possible he could be taken off close observation." This entry ignored the fact that David had attempted to hang himself on the night of March 22, an act which was documented in the progress report and seclusion note just one day before.

On March 24, 1992, an hour and half after defendant Mazick saw David, David was found hanging in his closet by a shoestring. Emergency CPR was performed and David was resuscitated. He was sent to Children's Hospital in Birmingham where it was determined that he suffered severe hypoxic brain damage. David remains in serious condition presently and currently functions at the level of a three-year-old.

A review of David's records from Eufaula Adolescent Center indicates that during a period of seventy days, David received only three and one-half hours of limited therapy with a social worker and only six hours of group therapy. In that same seventy days, however, David was secluded for a period of fourteen hours, was on dorm restriction for a period of ten days, and was kept in time out for a total of sixty-four hours.

While David was at Eufaula, gangs allegedly harassed, assaulted, abused, and intimidated students, including David. Students allegedly were subjected to an environment of verbal and physical abuse, and were also permitted to listen to satanic, pro-suicidal music. David was abused by both students and staff, a fact to which Jurls, McBride, Mazick, and Dykes were allegedly aware. David more frequently received punishment than treatment while at Eufaula. (Affidavit of Fowler and Kirby, Statement of Forte and medical records of David Dolihite). In addition, David was only seen by a psychiatrist twice during the seventy days he was in this mental health facility:

once when he was given the mandatory psychiatric assessment and again on March 19, 1992, four days before his death. (Medical records of David Dolihite.) According to documentation in David's record, David was seen only twice by the staff psychologist, once upon his assessment of January 23, 1992 and a second time on March 24, 1992, approximately one hour before his death.

The day following David's suicide attempt on March 24, 1992, an investigation was begun into the incident by the Department of Mental Health. According to its investigation report, the attempt David made to hang himself on March 22, 1992 was "not really made by David but was made by another boy, John Fowler." (See statement of Investigation.) According to the Department's investigation report, the mental health worker, Allen Forte, who had carefully and clearly documented the attempt of March 22, 1992, "made a mistake" when he wrote the information down. Mr. Forte has provided sworn testimony indicating that he was told to lie to the investigator by stating that someone other than David Dolihite had attempted to commit suicide on March 22. To quote Mr. Forte's sworn statement:

> Q Now, after David tried to hang himself and was injured on March the 24th, did anybody ask you to make an affidavit concerning the events of the night of the 22nd when this sheet was made out?
>
> A I was off this weekend when this happened, when he hanged himself. But when I got back to work, I was told that it wasn't David Dolihite that tried to hang himself that night.
>
> Q On the 22nd?
>
> A Right. I was told that I had made a mistake, and what I had written down on the observa-

tion sheet here, that I needed to change because I had made a mistake. And the investigator came down from Montgomery, and I written out an affidavit saying that I had made a mistake.

Q Had you made a mistake?

A No. But there's a lot of things that be swept under the rug, you know, so I written out an affidavit.

Mr. Forte's statement cites episodes of failure to provide medical care, episodes of physical abuse of the patients by the staff, and instances of sexual abuse of the patients by other patients. This sworn statement is corroborated by the affidavits of John Fowler, Billy Kirby, the records of Kathy Sawyer, the patient advocate, the Wyatt Committee reports, the photographs of the conditions in the seclusion room in Building 112, and the medical records of David Dolihite.

II. DISCUSSION

A. Standard for Summary Judgment

Rule 56(c) of the Federal Rules of Civil Procedure provides that summary judgment is appropriate where "there is no genuine issue as to any material fact and ... the moving party is entitled to a judgment as a matter of law." A district court must consider "all the evidence in the light most favorable to the non-moving party . . . and resolve all reasonable doubts in favor of the non-moving party." *Earley v. Champion International Corp.*, 907 F.2d 1077, 1080 (11th Cir.1990) (citations and internal quotations omitted). Summary judgment is proper "against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex Corp. v. Catrett*, 477 U.S. 317, 106 S.Ct. 2548,

91 L.Ed.2d 265 (1986). The non-moving party need make this showing only after the moving party has satisfied its burden. *Clark v. Coats & Clark, Inc.*, 929 F.2d 604, 608 (11th Cir.1991).

B. Section 1983 Cause of Action

Section 1983 provides a civil remedial vehicle for persons claiming violations of their rights secured by either the Constitution or by federal laws, "broadly encompass[ing] violations of federal as well as constitutional law." *Maine v. Thiboutot*, 448 U.S. 1, 4, 100 S.Ct. 2502, 2504, 65 L.Ed.2d 555 (1980). Plaintiffs' Sec. 1983 action is grounded upon allegations that defendants violated the due process component of the Fourteenth Amendment of the Constitution as well as substantive provisions delineated in *Wyatt v. Stickney*, 344 F.Supp. 373 (M.D.Ala.1972), aff'd in part, reserved in part, *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir.1974).

All defendants maintain that their actions violated no constitutional requirement, and that qualified immunity protects them from this lawsuit in their individual capacities. In *Harlow v. Fitzgerald*, 457 U.S. 800, 102 S.Ct. 2727, 73 L.Ed.2d 396 (1982), the Supreme Court held that "government officials performing discretionary functions generally are shielded from liability for civil damages insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known." Id. at 818, 100 S.Ct. at 2738. Because a "reasonably competent public official should know the law governing his conduct," id. at 818-19, 100 S.Ct. at 2738, the existence of clearly established law will defeat the immunity defense. *Anderson v. Creighton*, 483 U.S. 635, 107 S.Ct. 3034, 97 L.Ed.2d 523 (1987), explained that qualified immunity is a fact-sensitive inquiry, such that the "contours of the right [at issue] must be sufficiently clear that a reasonable official would under-

stand that what he is doing violates that right." Id. at 640, 107 S.Ct. at 3039. As previously noted, the facts must be analyzed in the light most favorable to the plaintiff. *Howell v. Evans*, 922 F.2d 712, 718 (11th Cir.1991).

Harlow's objective reasonableness test is applied through a two-part analysis:

> (1) The defendant public official must first prove that "he was acting within the scope of his discretionary authority when the allegedly wrongful acts occurred."
>
> (2) Once the defendant public official satisfies his burden of moving forward with the evidence, the burden shifts to the plaintiff to show lack of good faith on the defendant's part. This burden is met by proof demonstrating that the defendant public official's actions "violated clearly established constitutional law."

Rich v. Dollar, 841 F.2d 1558, 1563-64 (11th Cir.1988) (quoting *Zeigler v. Jackson*, 716 F.2d 847, 849 (11th Cir.1983)). Defendants have easily met their burden of demonstrating that they were acting within their discretionary authority. Because defendants deny that they violated any of David Dolihite's clearly established rights, the burden now shifts to plaintiffs to show that the legal norms allegedly violated by defendants were clearly established at the time in question, as well as to marshal "evidence sufficient to create a genuine issue of fact as to whether the defendant engaged in conduct violative of the rights guaranteed by clearly established law." *Stewart v. Baldwin County Bd. of Educ.*, 908 F.2d 1499, 1503 (11th Cir.1990); *Hutton v. Strickland*, 919 F.2d 1531, 1537 (11th Cir.1990). The bulk of this opinion is devoted to determining whether plaintiffs have met their burden.

It is well settled that state governments possess "a constitutional obligation to provide minimally adequate

medical care to those to whom they are punishing by incarceration." *Harris v. Thigpen*, 941 F.2d 1495, 1504 (11th Cir.1991) (citing *Estelle v. Gamble*, 429 U.S. 97, 104, 97 S.Ct. 285, 291, 50 L.Ed.2d 251 (1976)). If minimally adequate medical care is not provided, a plaintiff establishes an Eighth Amendment violation by proving that a defendant was "deliberately indifferent" to the plaintiff's serious medical needs. The Supreme Court has determined that persons who are subjected to involuntary civil commitment are "entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish." *Youngberg v. Romeo*, 457 U.S. 307, 322, 102 S.Ct. 2452, 2461, 73 L.Ed.2d 28 (1982).

The Court in *Romeo* made it clear that the Fourteenth Amendment due process requirements imposed on state officials who are entrusted to care for those who have been civilly committed to state institutions are considerably more rigorous than those imposed under the Eighth Amendment which are applicable to prisoners. Romeo announced that liability may be imposed under the due process clause when a "decision by [a] professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment." *Romeo*, 457 U.S. at 307, 102 S.Ct. at 2454. Although it is difficult to discern the degree to which this standard exceeds the requirements of the deliberate indifference standard,[2] and although it is clear

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[2]See, e.g., *Yvonne L. v. New Mexico Dept. of Human Resources*, 959 F.2d 883, 892-94 (10th Cir.1992) (confessing its inability to articulate the difference between the deliberate indifference and professional judgment standards).

The Third Circuit may have come closest to successfully grappling with the distinction between the standards. In *Shaw* By *Strain v. Strackhouse*, 920 F.2d 1135 (3rd Cir.1990), the court suggested that the professional judgment standard roughly approximated a reck-

that the professional judgment standard is the applicable one, the court concludes that all defendants have failed to demonstrate the absence of a factual issue concerning his or her compliance with either standard.

Despite the fact that all defendants disclaim any responsibility for David's attempted suicide, which led to his grievous injuries, in numerous cases courts have held that the law is settled that a constitutional violation occurs if jailers, with no training whatsoever in psychological evaluation, fail to take reasonable precautions to prevent suicides when put on notice of the suicidal tendencies of an inmate. See, e.g., *Tittle v. Jefferson County Comm'n*, 10 F.3d 1535, 1539-40 (11th Cir.1994) (en banc) (stating that individual officials with notice of an individual's suicidal tendencies are potentially liable for their deliberate indifference); *Greason v. Kemp*, 891 F.2d 829, 835-36 (11th Cir.1990) (collecting cases); *Waldrop v. Evans*, 871 F.2d 1030, 1036 (11th Cir.1989) (failure of prison staff member, who was not a psychiatrist, to notify competent officials of inmate's dangerous psychiatric state, may constitute a Sec. 1983 violation). In David's case, a person with known, documented suicidal tendencies was placed in an institution charged with treating that person's psychological problems. The law is at least as settled that persons trained to care for emotionally disturbed youths are also liable if put on notice of suicidal tendencies and they fail to take reasonable precautions to prevent suicide. See, e.g. *Greason v. Kemp*, 891 F.2d at 835.

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lessness or gross negligence standard. The court stated that "[p]rofessional judgment, like recklessness and gross negligence, generally falls somewhere between simple negligence and intentional misconduct." Id. at 1146. The point may be academic; defendants in the present case have not removed as a fact issue whether they acted with deliberate indifference, much less whether they exercised professional judgment.

The court, nonetheless, notes the difficulty it has encountered in attempting to divine the present commands of qualified immunity doctrine. Qualified immunity purports to insure that government officials are held personally liable only for violations of clearly established law. In part, the doctrine is designed to reassure government officials that a chosen course of conduct will not subject them to liability unless it is clear that the conduct is illegal. (Paradoxically, the determination of whether a particular defendant's actions violate clearly established law has become one of the more opaque and difficult tasks to besiege trial courts in recent years.)

Despite insisting upon a standard of absolute clarity to guide public officials, appellate courts have created a nebulous, increasingly cryptic standard to guide trial judges. This indeterminacy spawns litigation despite a stated objective of the qualified immunity defense of avoiding the expense and harassment of litigation. Perhaps the indeterminacy is inevitable, particularly in the field of mental health, where the fact-sensitive nature of qualified immunity is heightened. Each case seems to present a voyage into unchartered and dubiously navigable legal waters. This court, with trepidation, commences that voyage.

1. Liability of Defendants Maughon, Jenkins and Medical Money Management, Inc.

Doctors Maughon and Jenkins were employees of Medical Money Management, Inc., an entity which contracted with the Alabama Department of Mental Health and Mental Retardation to "[p]rovide psychiatric services to [Eufaula Adolescent Center] on a consulting basis." Doctors Maughon and Jenkins state, and the EAC agrees, that they exercised professional judgment and fully complied with the terms of their contract. Nonetheless, plaintiffs' expert Dr. Halpern, a psychiatrist, states that while

defendant doctors were acting pursuant to their contractual obligations, with respect to David Dolihite the doctors deviated from professional norms to such an extent that they cannot be said to have exercised their professional judgment. The court must determine whether qualified immunity shields the doctors from liability at the summary judgment stage.

Contrary to plaintiffs' contentions, the court determines that the Constitution of the United States was not violated by the doctors if the doctors fully performed their obligations under their contract so long as they did so through the exercise of their professional judgment. In fact, within the duties imposed by the terms of the contract, the Constitution did require the doctors to exercise their professional judgment. The contract bound the doctors to provide the following "consultative services": "admit residents to the facility; provide psychiatric evaluations and determine admitting diagnosis; write initial Treatment Plans and approve all master Treatment Plans and modifications to the treatment plans; prescribe medications, perform medication reviews, and issue PRN orders; conduct mental status examinations and give final diagnosis on all residents who are being discharged; provide expert testimony in court on an as needed basis; consult with facility clinical staff on an as needed basis; provide call coverage 24 hours per day." The contract also stated that defendants were "responsible for providing the necessary time to render the above services in a professional manner."

Disposition of the claims against the doctors is governed by a series of Eleventh Circuit cases directly confronting the manner by which the quality of a doctor's treatment is to be evaluated according to professional standards. See *Howell v. Evans*, 922 F.2d 712 (11th Cir.), vacated as moot, 931 F.2d 711 (1991), reinstated by unpublished order, sub. nom *Howell v. Burden*, 12 F.3d 190,

at asterisk-footnote (11th Cir.1994) (corrected opinion); *Greason v. Kemp*, 891 F.2d 829, 835-36 (11th Cir.1990); *Waldrop v. Evans*, 871 F.2d 1030 (11th Cir.1989); *Rogers v. Evans*, 792 F.2d 1052 (11th Cir.1986). Most recently in *Howell v. Evans*, while applying the Eighth Amendment standard, the court reiterated that "because the mere negligent diagnosis or treatment of a patient does not constitute deliberate indifference, [t]he law must . . . be clear and specific enough for the medical official to know that his [or her] actions rise to the level of deliberate indifference and are not just negligent." *Howell v. Evans*, 922 F.2d at 719 (citation omitted). Moreover, medical treatment cases are unique, for the standard that must be clearly established need not depend solely on legal precedent. The court stated that "the contemporary standards and opinions of the medical profession also are highly relevant in determining what constitutes deliberate indifference to medical care." Id.; see *Greason v. Kemp*, 891 F.2d 829, 835 (11th Cir.1990); *Rogers*, 792 F.2d at 1058.

Thus, two avenues exist by which a plaintiff may demonstrate deliberate indifference or the absence of medical judgment: a plaintiff may show that the facts are similar to prior cases where a Sec. 1983 violation was found, or a plaintiff could, and perhaps must, "produce opinions of medical experts which assert that the official's actions were so grossly contrary to accepted medical practices as to amount to deliberate indifference." *Howell v. Evans*, 922 F.2d at 719-20. Regarding the first method of showing deliberate indifference, the court noted that the standard "focuses on the failure to provide or allow proper treatment in the face of information which reasonably should compel action." Id. at 720.

The court further explained the parameters of the first method of proving deliberate indifference by stating that such "indifference is often manifest by a refusal to act

when certain actions were or should have been known to be necessary, rather than simply a failure to act. In some cases, however, if an official knows or should know that certain treatment is necessary, and he delays in providing such treatment when he reasonably should know that such delay can be hazardous, his actions could constitute deliberate indifference." Id. at 720. With regard to the second avenue the court found, "relevant to the actions of a medical official, if the plaintiff demonstrates that a reasonable doctor in the defendant's position would have known that his actions were grossly incompetent by medical standards, then a jury could find deliberate indifference and qualified immunity would be inappropriate." Id.

In the present case, the psychiatrists' actions theoretically depended upon medical judgments; thus plaintiffs must do more than appeal to prior cases to demonstrate that the law is clearly established. Id. at 720. The affidavit of Dr. Abraham L. Halpern, a psychiatrist, serves this function. In the affidavit, Halpern notes that the doctors were members of David's treatment team, and therefore knew, or should have known,[3] of the increasing episodes of self-mutilation, disruptive behavior, mood swings, psychotic episodes, and suicide threats and attempts that occurred over a 70-day period.[4] If as Dr. Halpern has stated, the doctors knew or should have known of these documented problems of David, failing to act appropriately could constitute the absence of the exercise of pro-

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[3]If a doctor fails to know something the doctor should have known, the doctor may be found to violate the constitutional standard. See, e.g., *Waldrop*, 871 F.2d at 1036.

[4]Defendant McBride stated that he informed the entire treatment team, including Dr. Maughon and eventually Dr. Jenkins, that David harbored suicidal ideations before coming to Eufaula. McBride depo. at 9-11. Both doctors were apprised of David's suicidal ideations and gestures. Id.

fessional judgment. Dr. Halpern has so expressed his expert opinion in his affidavit.

Dr. Halpern stated that the doctors "made no attempt to properly evaluate and treat David" for his mental disorders. Affidavit #2 at p. 3. Given the information in the doctors possession, Dr. Halpern states that the doctors "should have prescribed antidepressant medication for this child" and should have monitored the child's response to this medication. Id. Because only the psychiatrists could prescribe medication, defendants Jenkins and Maughon could not possibly believe that this duty was not encompassed by the terms of their contract. In addition, Halpern states that the doctors should have directed that David "receive intense and lengthy individual therapy." Id.

Dr. Halpern states that even after several instances of David's exhibiting severe mental disturbance, the doctors performed no testing or in-depth evaluation of David's condition. Halpern states that Defendant Maughon's conclusion—formed after David's March 15 seclusion for bleeding on the walls and defecating on the floor—that David's problems were behavioral could not have been based on any degree of professional judgment. Halpern states that there was "no effort on the part of Dr. Maughon to perform any tests of standard psychiatric evaluation of David." Id. at p. 4. Halpern characterizes Maughon's efforts at evaluation as a "total departure from the professional judgment and standard which should have been followed." Id.

Similarly, both Drs. Maughon and Jenkins ignored the report indicating that on March 21st David was placed in seclusion for his self-directed violent behavior. Not only did the doctors fail to see David after this report was received by Dr. Jenkins, but they also failed to ask the Ph.D. psychologist to see David. Id. at 5. Dr. Halpern, then, alleges more than that the professional opinions of

defendants Maughon and Jenkins were inadequate; he alleges that they failed to formulate and act upon any professional opinion at all.

The primary findings of Dr. Halpern are as follows:

> 1. Dr. Jenkins' and Dr. Maughon's treatment of this child was such a total departure from accepted professional judgment, practice or standards, that it cannot be said that their treatment was based on accepted professional judgment or psychiatric practice in the general community.
>
> 2. As a result of the departure from accepted professional judgment on the part of the psychiatrists and on the part of the staff at Eufaula Adolescent Center, including Dr. Mazick, Dr. Jenkins, Dr. Maughon, Karen Jurls, and Andrew McBride, David was not given necessary and essential individual treatment to afford him a realistic opportunity to be cured or to improve his mental condition.
>
> 3. That the lack of treatment by Dr. Jenkins and Dr. Maughon demonstrated deliberate indifference to the serious medical needs of this child.
>
> 4. That as a result of this lack of treatment combined with the abuse, neglect, intimidation and fear for his personal security to which David was subjected, David's condition deteriorated significantly while he was a patient at Eufaula Adolescent Center.
>
> 5. That within a reasonable degree of medical probability, had David received the necessary and essential treatment from the staff and psychiatrists and had he not been subjected to the atmosphere of abuse, neglect, and intimidation at Eufaula Adolescent Center, David's condition would not have deteriorated in the manner that

it did and his ultimate suicide attempt would not have occurred when it occurred.

6. That it was a combination of the above factors, i.e., the lack of treatment on the part of the psychiatrists, the lack of treatment on the part of the staff and the intimidating[,] abusive[,] and insecure conditions at Eufaula, which ultimately caused the deteriorating condition of David's mental health and his ultimate suicide attempt for which he is so devastatingly injured.

The doctors, in defense, rely on the terms of the contract which provide that Drs. Maughon and Jenkins are employed on a "consulting basis." The doctors claim this provision indicates that their duties were not triggered unless they were requested by the personnel of Eufaula. Nonetheless, the doctors acknowledge that they had authority to intervene at any time to direct the treatment of patients. The doctors also acknowledge that they were part of the "treatment team." The procedure for governing treatment team meetings states: "The Treatment Team will meet as often as necessary with special meetings called at the request of a member of the team." PEx. 20, "Treatment Teams" (emphasis supplied). Given this broad authority, Dr. Halpern states that the failure to exercise the authority reveals an absence of medical judgment.

In addition, the "Professional Services Plan for Eufaula Adolescent Center," which outlines the admissions criteria for the center, plainly states that the "currently actively suicidal adolescent is not appropriate for initial placement at Eufaula. Such an individual, for that period, requires the security of hospital ward placement until stabilized. Once so stabilized, however, such adolescents are likely to be excellent candidates for the pro-

gram." (emphasis in original). Defendant McBride stated that a child who expresses the thought and intent to commit suicide is "actively suicidal." McBride depo. at 43.

Every member of David's treatment team possessed information sufficient to indicate that at the time of admission, throughout his stay at Eufaula, David was actively suicidal. See id. at 8-9; Fletcher Hamilton's affidavit. Yet none of the members of the treatment team attempted to have David transferred to a more suitable facility. Every member of the team possessed the authority to at least recommend that David be transferred. See Jurls depo. at 118-122. That each one failed to act, including both doctors, could indicate a failure to exercise professional judgment. Because there is expert testimony that Drs. Maughon and Jenkins exhibited deliberate indifference or an absence of medical judgment in their treatment of David, the motion for summary judgment of Drs. Maughon and Jenkins, and Medical Money Management[5] on the ground of qualified immunity is denied.

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[5]Assuming that a corporation, no less than an individual, may invoke the qualified immunity defense, *DeVargas v. Mason & Hanger-Silas Mason Co., Inc.*, 844 F.2d 714, 723 (10th Cir.1988); *Jones v. Preuit & Mauldin*, 808 F.2d 1435, 1440-42 (11th Cir.1987) (private partnership may invoke qualified immunity defense), vacated in part on other grounds, 822 F.2d 998 (11th Cir.1987), opinion vacated and rehearing granted en banc, 833 F.2d 1436 (11th Cir.1987), upon rehearing, 851 F.2d 1321 (11th Cir.1988) (en banc), vacated on other grounds, 489 U.S. 1002, 109 S.Ct. 1105, 103 L.Ed.2d 170 (1989), and assuming that a corporation can not be held liable for a Sec. 1983 violation under a theory of respondeat superior, *Sanders v. Sears & Roebuck & Co.*, 984 F.2d 972 (8th Cir.1993); *Rojas v. Alexander's Dept. Store*, 924 F.2d 406 (2d Cir.1990), the court nonetheless concludes that Medical Money Management's motion for summary judgment is due to be denied.

2. Defendant Karen Jurls

Karen Jurls, a professional social worker, was David's primary therapist, and like Jenkins and Maughon, Jurls approved David's treatment plan and served on his treatment team. Similar to the psychiatrists, Jurls is properly characterized as the functional equivalent of a medical official, subject to the strictures of Howell v. Evans, 922 F.2d 712 (11th Cir.1991).

As a member of the treatment team, Jurls was privy to the admittance information on David Dolihite. She knew of his suicidal ideations and of the family history of suicide. According to the affidavit of Alan Isaacson, a clinical social worker, Jurls failed to meet the most basic standards for rapid evaluation and treatment of individuals who are admitted for treatment of mental disorders. Jurls knew that David was actively suicidal, and according to Eufaula's regulations, Jurls knew that David should not have been admitted and should be transferred. See *Greason*, 891 F.2d at 833, 835-36 (suggesting that a defendant's liability could hinge upon failure to seek transfer of a suicidal person to an adequate facility).

On at least two occasions, despite her knowledge of David's need for intense therapy, Jurls failed to appear for David's individual therapy sessions because of time constraints. (See Medical Records). Jurls allegedly used time out and restraint methods as punishment rather than as therapy. Jurls allegedly also knew that abuse was being inflicted on students and acted indifferently toward ending it. Not only did Jurls reportedly engage in abusive behavior herself, but there is evidence that she was motivated by a punishment driven philosophy rather than a therapy driven one. See Dykes depo. at 100; Mazick's letter of 3/17/1992. On March 17, 1992, Mazick officially reprimanded Jurls for her inability to conform

to a therapeutic regimen, as well as for her own demonstration of verbal abuse toward a patient. PEx. 15.[6]

Furthermore, Jurls denies that on March 24, 1992, she knew that David had attempted suicide by hanging on March 22. The record clearly revealed that seclusion had been employed to stop David from hanging himself. Had she known about this, she would have abdicated all professional judgment by allowing David off "close observation." Yet, she did release David from "close observation," and this indifference could well be viewed as proximately causing David's death.

Jurls denies seeing the documentation of the March 22, 1992 attempted suicide. Yet she did know about a suicide pact involving David. Both David and John Fowler told Jurls that David had tried to kill himself. Jurls denies that the entry was accurately made, and disputes the affidavit of Allen Forte which alleges David was indeed the potential suicide victim. Although Jurls alleges that Dykes told her an error was made in the chart, and that some other resident actually tried to hang himself, she does not know who that child was, nor did she inquire as to who that child was. Jurls Depo. at 161-65. A jury is entitled to disbelieve this testimony which is particularly curious in that the central social worker was not interested in who had actually attempted suicide. Jurls' credibility being at stake, the issue is a triable one.

Jurls' story is not unlike that of the defendant in *Howell v. Burden*, 12 F.3d 190 (11th Cir.1994). In *Burden*, the defendant claimed he had not read a specific document that would have informed him of plaintiff's serious medical needs. The court held that the jury was entitled to disbelieve *Burden*, and to find that he had indeed read

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[6]Jurls' antipathy toward Mazick indicates that her approach to treating the residents was not aligned with their therapeutic interests.

the document in question. Id. at 193. Similarly, a jury may determine that Jurls read the report of Allen Forte, that she knew that David was suicidal, and that she acted with deliberate indifference to that knowledge. As the court stated in *Greason v. Kemp*, 891 F.2d 829 (11th Cir.1990), "Where . . . personnel directly responsible for [resident] care have knowledge that a [resident] has attempted, or even threatened, suicide, their failure to take steps to prevent that [resident] from committing suicide can amount to deliberate indifference." Id. at 835-36.

3. Defendant Mazick

Dr. Mazick was the clinical director at EAC and was a policy-making administrator. According to Mazick, "I had the responsibility . . . to create the clinical environments" that would ensure that children at Eufaula were not physically or mentally abused or neglected. Mazick depo. at 83. He supervised the activities of Maughon, Jenkins, Jurls, and McBride, and was responsible for making sure David was properly evaluated and treated. Id. at 119, 127-28. Mazick, as a licensed psychologist, was qualified to diagnose mental illness. Thus, the determination of his eligibility for immunity is also governed by the *Howell v. Evans*, 922 F.2d 712 (11th Cir.1991), standard governing medical professionals.

After David arrived at EAC, he remained there for ten days before receiving any therapy or receiving any form of psychiatric or psychological assessment. After the assessment, Mazick recognized that David suffered from suicidal ideations, had a family history of suicide, and made suicidal gestures and attempts. Nonetheless, in violation of EAC policy, Mazick made no attempt to have this "actively suicidal" child transferred to another facility.

Dr. Mazick rarely communicated with, and allegedly wholly neglected to supervise, the social worker Karen

Jurls. Dr. Mazick failed to review David's clinical course on a regular basis and failed to monitor his condition and response to treatment by Jurls. Indeed, although Dr. Mazick's responsibility was to supervise therapeutic care, he never reviewed David's chart until one hour before David hanged himself. Not only did Dr. Mazick fail to diagnose David, but he also failed to insure that one of the psychiatrists was consulted about David in light of David's continuing suicidal threats and self-destructive acts. In the expert opinion of Fletcher Hamilton, a psychologist licensed in the State of Alabama, such conduct can only be characterized as a refusal to exercise professional judgment. A jury will have to evaluate the competing expert contentions.

For Mazick to be liable in his supervisory capacity, his conduct must be found to violate *Greason v. Kemp*, 891 F.2d 829 (11th Cir.1990), three-prong test: "(1) whether, in failing adequately to train and supervise subordinates, he was deliberately indifferent to a [resident's] mental health care needs; (2) whether a reasonable person in the supervisor's position would know that his failure to train and supervise reflected deliberate indifference; and (3) whether his conduct was causally related to the constitutional infringement by his subordinate." Id. at 836-37. A jury could conclude that Mazick's conduct, evaluated in light of the three-prong test, renders him liable in his supervisory capacity.

Mazick's conduct, moreover, was not unlike the conduct analyzed in *George v. McIntosh-Wilson*, 582 So.2d 1058 (Ala.1991). In *George*, the administrator of a mental health institution who formulated policies and procedures, including individual rehabilitation plans, and who was responsible for assuring compliance with formulated policies, was found to be potentially liable on the basis that the defendant failed to assure that there was "ongoing communication between the administration, psychi-

atric staff, and direct care staff." Id. at 1063. Likewise, Hamilton faulted Mazick because there was "no evidence of communication or clinical supervision between Jurls and Dr. Mazick concerning David's clinical treatment." This absence of communication extended to Mazick's failure to properly communicate with the two psychiatrists.

Consequently, Mazick could also be liable for "not taking reasonable steps to train" the employees. *City of Canton v. Harris*, 489 U.S. 378, 390, 109 S.Ct. 1197, 1205, 103 L.Ed.2d 412 (1989). Although Mazick's responsibility included ensuring that the staff at Eufaula was adequately trained, Mazick depo. at 210, David was seen by neither a psychologist nor psychiatrist for nearly two months. Indeed, during the seventy days David resided at Eufaula, he received only three and one-half hours of individual therapy with a social worker and only six hours of group therapy. Besides his initial evaluation, David was seen only once by a psychiatrist. Whether this dearth of treatment was "a matter of gross incompetence, negligence, or medical judgment is disputed and a proper subject of expert testimony." *Rogers v. Evans*, 792 F.2d 1052, 1062 (11th Cir.1986).

4. Liability of Andrew McBride

McBride, a psychologist at Eufaula on the date the incident occurred, conducted a psychological assessment in order that David be admitted to Eufaula. He has been a psychologist at Eufaula since 1987, and was a member of David's treatment team. When David first arrived at Eufaula, McBride did an initial intake, interviewed David, and reviewed his psychological evaluations. McBride knew David was suicidal when he arrived at the center. McBride depo. at 7-9. Being part of the treatment team that met every week, McBride knew of David's suicidal ideations, of the seclusions, dorm restrictions, and time

outs. McBride knew about the conditions in Building 112, and was aware of David's injuring himself and threatening suicide.

McBride saw David on Monday morning after the initial attempt to hang himself. McBride did not perform a suicide assessment on David at that time, despite his awareness of Mr. Forte's report, McBride depo. at 28-32, and despite his knowledge that David had been secluded over the weekend, had been in time out prior to seclusion, and had attempted to injure himself while in the time out room. McBride depo. at 34, 35, 36. Even if one believes that McBride failed to review the time out sheet describing David's self-injurious behavior, McBride could be considered to have abdicated his responsibility to exercise professional judgment. After this episode, McBride did not engage David in any individual therapy. According to the expert affidavits of Fletcher Hamilton and Alan Isaacson, a licensed clinical social worker, McBride's conduct did not comport with the exercise of professional judgment.

McBride knew that there were gangs at Eufaula. Id. at 55. He knew that there had been incidents of abuse. He stated that he was unsure whether such an environment could aggravate David's condition. McBride knew that a child who expressed the thought and intent to commit suicide was an actively suicidal child. He knew that David fit this description. He also knew that Eufaula's own policy forbade the retention of an actively suicidal child. See supra part B.1. Nonetheless, he did not consider transferring David to another facility. McBride's failure to recommend transfer could be considered an abdication of professional judgment. See *Greason*, 891 F.2d at 833, 835-36 (suggesting that a defendant's liability could hinge upon failure to seek transfer of a suicidal person to an adequate facility).

Whether professional judgment was in fact exercised requires a consideration of factors that cannot be evaluated in the absence of a fully developed factual record. The affidavits presented by plaintiffs pose a clear factual dispute. McBride, along with each of the above defendants, possessed sufficient personal knowledge of David Dolihite's case to expose himself to Section 1983 liability. A different line of inquiry is required to determine whether the link between the alleged violations of David Dolihite's constitutional rights and the other defendants' activity exists.

C. Section 1983 Supervisory Liability

To determine the extent to which defendants Dykes, Poundstone, and King may be liable, one must consider the parameters of supervisory liability. Liability may not be premised on a theory of respondeat superior. *Monell v. Department of Social Services*, 436 U.S. 658, 690, 98 S.Ct. 2018, 2035-36, 56 L.Ed.2d 611 (1978). Instead, liability arises when plaintiffs are capable of demonstrating a link between the supervisory defendant's behavior and the deprivation of David's constitutional rights. Although *Greason v. Kemp*, 891 F.2d 829 (11th Cir.1990), delineates and applies the Eleventh Circuit standard of supervisory liability, see supra part B.3., this court supplements its analysis with reference to *George v. McIntosh-Wilson*, 582 So.2d 1058 (Ala.1991), a similar case applying the professional judgment standard in the context of supervisory liability.

In *George v. McIntosh-Wilson*, 582 So.2d 1058 (Ala.1991), the Alabama Supreme Court examined the breadth of Sec. 1983 liability as it related to administrators of a mental health care facility. *George* stated that supervisory liability would attach "where the policies of the [h]ospital as formulated or applied result in such a lack of training

and supervision as to constitute deliberate indifference to clearly established constitutional rights to a reasonably safe environment. Such indifference constitutes a 'personal involvement' in the alleged violation." See also *McLaughlin v. City of LaGrange*, 662 F.2d 1385, 1388 (11th Cir.1981) (per curiam) (requiring personal involvement, or evidence of policy or custom, in order to find supervisory liability). The court added that "policy-making administrators would be liable for the constitutional deprivations caused by their subordinates if they exhibited such a degree of indifference to compliance with ... policies as to demonstrate that they did not base their actual administrative decisions or actions on the professional judgments embodied in the policy." *George*, 582 So.2d at 1063.

In the present case, the policies requiring enforcement include not only those that defendants actually attempted to implement, but those that arise out of the landmark case of *Wyatt v. Stickney*, 344 F.Supp. 373 (M.D.Ala.1972) (Johnson, J.) (standards for the mentally ill), aff'd in relevant part sub.nom. *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir.1979), and its progeny. In the 1972 decision, Judge Johnson ordered the Department of Mental Health and Mental Retardation to bring its facilities in compliance with certain minimum constitutional standards (the *Wyatt* standards). The *Wyatt* standards promulgated by the court have been the source of litigation for over two decades.

On February 28, 1975, this court determined that the *Wyatt* standards be extended to cover the Eufaula Adolescent Center "at least insofar as these standards have relevance to [the Eufaula] facilities." The court further indicated that the staffing ratios specified in the 1972 *Wyatt* order applied in a generalized sense to Eufaula, but that the Eufaula ratio did not have to mirror the specified ratio.

The *Wyatt* litigation continued throughout the 1970s, culminating in the court's finding that gross constitutional deficiencies remained and that the governor should be appointed as receiver of the state system.[7] Under the compliance plan approved by the court, the defendants were to achieve compliance with all but a few of the *Wyatt* standards within eighteen months. In 1981, the plaintiffs returned to court to ensure that the defendants had complied with the plan. The defendants, in turn, sought to modify the 1972 order by eliminating the standards and substituting in their place a requirement that defendants obtain accreditation of the state's mental illness facilities by the Joint Commission on the Accreditation of Healthcare Organizations (JCAH or JCAHO) and certification of the mental retardation facilities through Title XIX of the Social Security Act. The defendants contended that the *Wyatt* standards exceeded minimum constitutional requirements.

In 1986, the parties submitted to the court a proposed consent decree intended to resolve the outstanding disputes. The court approved the proposed decree on September 22, 1986. See *Wyatt v. Wallis*, 1986 WL 69194, (M.D.Ala. 9/22/86). The decree contained several provisions of particular significance to this litigation. First, all parties agreed in the decree that all prior orders and standards issued by the court regarding the obligations of the state system, including the original *Wyatt* standards, were to remain in force and that the defendants would "continue to make substantial progress in achieving compliance" with these orders and standards. Decree of 9/22/1986 at pp 6, 7. Second, defendants agreed "to con-

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[7]The following is a skeletal outline of the pertinent events in the *Wyatt* litigation. For a more detailed account, from which this version has been condensed, see *Wyatt, By and Through Rawlins v. King*, 811 F.Supp. 1533 (M.D.Ala.1993) (Thompson, J.); PEx. 13.

tinue to make substantial progress in placing members of the plaintiff class in community facilities and programs." Id. at p 9. Additionally, the 1986 decree required the DMHMR to: (1) make substantial progress in placing members of the plaintiff class in community facilities and programs; (2) make all reasonable efforts to achieve full accreditation of Alabama's mental health facilities by the Joint Commission and Accreditation of Hospitals and to maintain such accreditation; (3) to develop and implement an internal advocacy program and a quality assurance program.

On January 18, 1991, at least five years after adoption of the consent decree, the defendants moved the court for a finding that they had met their obligations under the decree and for an order terminating the lawsuit. In response to this motion, the court appointed an expert to investigate the factual issues relating to defendants' compliance. See *Wyatt, By and Through Rawlins v. King*, 803 F.Supp. 377, 381 (M.D.Ala.1992). Judge Thompson has, to date, declined to terminate the lawsuit.

During the course of this protracted litigation, the *Wyatt* Consultant Committee has investigated the treatment practices of the DMHMR and has offered numerous criticisms and suggestions. Their reports indicate that the promise of adequate treatment has yet to be fulfilled and that grave deficiencies remain in the treatment that is offered. On March 19, 1991, the Committee, which was created to provide independent consultation to the defendants as well as to inform plaintiffs of defendant's progress or lack thereof, submitted a report which reviewed the deficiencies in depth. PEx. 5. The March 19, 1991 report specifically addresses problems at Eufaula. The report states that Eufaula is not accredited by JCAH, but is instead accredited by an organization with very few guidelines applicable to a children's residential facility. The current accrediting entity has no spe-

cific standards dealing with restraint or seclusion, practices widely used at Eufaula. The Committee explicitly stated that this accreditation was an inadequate substitute for JCAH accreditation. In addition, the Committee reported the following:

> 1. Gross inadequacies existed in the charts, specifically in histories, the psychiatric examinations, the overall clinical assessments, and the treatment planning. In a number of charts randomly selected there was no history or clinical assessment at all, the psychiatric examination was totally inadequate, and the treatment plans were "canned" and lacked any individualization.
>
> 2. Review of the ongoing treatment revealed that the foregoing problems were not confined to documentation, but reflected deeper problems in the facility and in the staff's clinical understanding of the children. We were struck by the lack of sensitivity on the part of the treatment staff to the painful wounds that these children were struggling with.
>
> 3. There was a lack of ongoing therapy in other parts of the mental health system for the families of Eufaula, and a lack of ongoing contact between the community mental health agencies and Eufaula—despite the fact that many of these children will be discharged right back to the troubled families from which they came in the first place.

The Committee also stated:

> The above problems, though deeply disturbing, are in fact not as fundamental as another one: that most of these children probably don't belong at Eufaula in the first place. Judges send them there in large part because there are no alternatives. It was the conclusion of the Com-

mittee, shared by at least two senior members of the Department, that the vast majority of the Eufaula children needed different kinds of services than they were getting:

> (a) a spectrum of community residential settings that for the most part could be unlocked, with high quality clinical treatment, and with an emphasis on treating the families as well as the children when this was clinically indicated; and
>
> (b) a small, locked facility for those children who, for some period of time, cannot be treated in an open setting. Whether open or locked, all of these settings should be located in areas that are not geographically isolated so that (1) families can visit and be involved in the treatment process when this is clinically indicated; (2) staff who are involved in treating the children can interact with staff who are treating the families; (3) the children can be kept in the school system when this is realistic and practical; and (4) high quality staff can be recruited more easily than is the case in a remote facility like Eufaula.

The report identified a number of steps the DMHMR needed to take to address the problems. See Committee Report, PEx.5. The report also noted that defendant Poundstone "agreed to conduct a two-month study of the use of restraints and seclusion at Eufaula, and in particular the use of 'hard' restraints." PEx. 5., at p. 8.

The above report is representative of those received by defendants. The degree to which defendants have complied with this court's orders is appropriately determined by reference to such criticisms and the response such criticisms evoked. Most importantly, however, the continuing deficiencies reflect a non-compliance with the

Wyatt standards. In the case at bar, the failure to comply with the spirit and letter of *Wyatt* allegedly created an anti-therapeutic environment which was a proximate cause of David's injuries.

1. Liability of Anthony Dykes

Anthony Dykes was the director of Eufaula Adolescent Center in January 1992; his responsibilities were "to manage and budget, to allocate resources, to do short and long-term planning for the facility, to maintain a positive image with the community non-referral resources." Dykes depo. at 9-10. Although he possessed no formal clinical training, he could overrule any decision that Dr. Mazick made. Mazick depo. at 80. He was aware of the Wyatt standards, the failure of Eufaula to meet many of them, and moreover, (along with Poundstone and King), is charged with taking no steps to insure that JCAH accreditation was obtained.

The JCAH process works to "assure that the [mental health] facility itself is structured so that decisions will be professionally made." *Woe v. Cuomo*, 729 F.2d 96, 106 (2d Cir.1984). The introduction of JCAH criteria to an institution increases the "likelihood that professional judgments will govern individual treatment decisions within the institution. [After all] JCAH standards address the existence, quality, and specificity of patient treatment plans." Id. at 106. Thus, the alleged failure even to seek JCAH accreditation, in the face of a court ordered mandate to do so, not only indicates a violation of clearly established law that plaintiffs contend has led to serious inadequacies in treatment, but it is evidence of an unwillingness to take the steps necessary to ensure that the Eufaula staff will be able to exercise the professional judgment that *Romeo* requires. As one court has aptly stated: "[The] [l]ack of personnel capable of exercising professional judgment ... itself represents a failure to pro-

vide constitutionally safe conditions." *Society for Good Will to Retarded Children v. Cuomo*, 572 F.Supp. 1300, 1345 (E.D.N.Y.1983).

The Second Circuit has determined that the absence of JCAH accreditation deprives a mental health facility and its supervisors of being able to make even a prima facie showing of adequate care. *Woe*, 729 F.2d at 107. Indeed, the Report of the *Wyatt* Committee indicates several shortcomings which epitomize an absence of professional judgment. The consultants reported that treatment plans were "canned" and not tailored to individual needs. The chairman of the *Wyatt* Committee, Dr. Okin, wrote to then Commissioner Horsley, on May 14, 1990, that patients' charts often contained no clinical assessment or history, and that the psychiatric examination was wholly inadequate. PEx. 7. In light of these criticisms, Judge Thompson wrote to Commissioner Horsley on March 22, 1990, that the Department of Mental Health should develop "by no later than mid-August 1990, a detailed plan providing both a conceptual framework for children's mental health services and an operational plan to develop needed community based services." PEx. 8. Despite the purported policy of DMH to seek JCAH accreditation, see Pltf # 10, dated 7/23/90, no one sought this accreditation.

Dykes was clearly a policy-making administrator, within the meaning of *George v. McIntosh-Wilson*, 582 So.2d 1058, 1063 (Ala.1991), for all of Eufaula's policies and procedures are signed by Dykes. See Dykes depo. at 68-73. Dykes was aware of Eufaula's obligation to work toward JCAH accreditation and was aware of the numerous changes the *Wyatt* Committee believed needed to be implemented. Nonetheless, Dykes did not share all of this information with Dr. Mazick, (Dykes depo. at 38-40), nor did he take other adequate steps to ensure that the *Wyatt* mandate was fulfilled. Whether Dykes and Eufaula

were actively seeking JCAH accreditation, and thus constitutional compliance, or whether they were pursuing a mere "paper policy", is a factual issue that precludes summary judgment. See *George*, 582 So.2d at 1063.

Moreover, Dykes knew of the widespread abuse allegedly taking place at Eufaula. See 1992 Advocacy Monitoring Report, Pltf. # 7. He knew of reported assaults by the staff, as well as assaults of other students, and of sexual abuse at the center. The affidavits of Billy Kirby, John Fowler, Allen Forte all indicate that abuse was a significant hindrance to treating the residents. See also Internal Advocacy Report of Kathy Sawyer, PEx. 11. Yet Dykes took no identifiable steps to prevent the abuse; he also failed to require professional investigations into the allegations of abuse. He allegedly did nothing to eliminate the presence of gangs at Eufaula. In addition, Dykes knew when children were injuring themselves, for he received reports of both threatened injuries and actual ones. Although it was within Dykes' responsibility to cure these ills, Dykes depo. at 68-74, he allegedly took insignificant measures to do so.

Dykes also knew that seclusion was being employed inappropriately at the Center. He received the copy of the Internal advocacy report which outlined numerous hazards associated with the practice of seclusion at Eufaula. Indeed, as far back as September 14, 1988, Kathy Sawyer enjoined Dykes: "Your assistance is needed to help insure that more acceptable seclusion policies and practices are employed at Eufaula. Additionally ... I ask that your Clinical Policy Committee develop a policy in this area . . . " PEx. 11, p. 1. No evidence has been submitted that any serious attempt to reform the seclusion policies and facilities was ever undertaken, despite the significance of the problem identified by Kathy Sawyer. A jury could find such inattentiveness constituted

deliberate indifference and that *Greason*'s three-prong test for supervisory liability was satisfied.

2. Liability of Emmett Poundstone

Emmett Poundstone was the Associate Commissioner for Mental Health, and as a policy-making administrator, his liability is also governed by *Greason* and *George*. Before becoming the Associate Commissioner, Poundstone became intimately familiar with the Wyatt standards as an attorney in the legal division of the Alabama Department of Mental Health. Poundstone was copied on all correspondence of the *Wyatt* Committee.

Poundstone knew of the consent decree requiring that JCAH accreditation be sought for Eufaula, but despite signing the document that indicated obtaining such accreditation was a department goal, no evidence was submitted that Poundstone did anything of significance to achieve this goal. In other respects, there is evidence that Poundstone failed to meet the *Wyatt* standards. Poundstone was aware of the *Wyatt* Committee's findings of "gross inadequacies," but Poundstone simply disagreed with these conclusions. Poundstone depo. at 86. He acknowledged that there were deficiencies in clinical assessments, treatment plans, and psychiatric examinations. Poundstone depo. at 95-99. Poundstone also knew of the seclusion area in Building 112 and that it continued to be used for seclusion despite Kathy Sawyer's condemnation of seclusion practices at Eufaula. PEx. 11.

In addition, Poundstone possessed the Advocacy reports indicating that violence was a routine feature of the Eufaula environment. Poundstone also had access to the complaints filled out by children who were beaten. The evidence submitted on defendant's motion for summary judgment presents a question of whether Poundstone was deliberately indifferent to making the facility reason-

ably safe so that the summary judgment motion must be denied.

A revealing example of evidence of Poundstone's indifference is found in his remarks concerning Judge Thompson's statement that "we agreed . . . that the Department should develop . . a detailed plan providing both a conceptual framework for children's mental health services and an operational plan to develop needed community based services to end placement at Eufaula." May 1990 letter to Horsley. Poundstone contends that the Department agreed to no such thing, and states that "the Department did not follow through." Poundstone depo. at 107.

The deficiencies indicated by Judge Thompson's letter, the Wyatt Committee, and the Child Advocacy Reports were allegedly frequently ignored by Poundstone. Plaintiffs contend that the deficiencies created a non-therapeutic environment in which children, such as David, grew increasingly troubled. The fact-finder would need to determine on a fully developed record whether Poundstone exhibited such a degree of indifference to compliance with the policies of Eufaula, including those prescribed by Wyatt, that his administrative decisions were made without the benefit of professional judgment. *George*, 582 So.2d at 1063. The evidence suggests that Poundstone could be found liable in his supervisory capacity under *Greason*'s three-prong test.

3. Liability of Royce King

Because Royce King was the Commissioner of the Department of Mental Health at the time of David's suicide attempt, he was a policy-making administrator whose liability is analyzed under the same rubric as is the liability of Dykes and Poundstone. Despite King's complete lack of clinical training (King was successful in business before becoming a public servant), his primary defense that

he cannot be liable because he delegated his responsibility is unpersuasive. Because the duty to know and take responsibility is broader than the explicitly stated law (to which King readily admits his ignorance), King "may take no solace in ostrichism." *Little v. Walker*, 552 F.2d 193, 197 (7th Cir.1977). A jury is entitled to decide whether King legitimately delegated his responsibilities or whether he actually abandoned them. See *George v. McIntosh-Wilson*, supra.

King's testimony is evidence that he exercised no professional judgment, making no efforts to see that JCAH accreditation was obtained, and making no attempt to ensure that the person who had mentioned attempting to obtain this accreditation (Poundstone) was following through on obtaining the accreditation. King depo. 30-33. From Mr. King's deposition, it does not appear King knew the difference between JCAH standards and the standards that Eufaula met.

King stated that he was "not familiar" with the *Wyatt* Committee and that he had never met with them. King depo. at 35-36. King has read none of the material from the Committee. At no time did King personally investigate as to whether Eufaula met the appropriate standards. Id. at 40-41. Moreover, King could not even begin to articulate, in the most general way, what the *Wyatt* standards involved. Id. at 50-51. King was only "vaguely familiar" with Eufaula's policies and procedures. Id. at 52, 55.

King did receive patient advocacy reports documenting abusive conditions at Eufaula, and he did "scan those." Id. at 42-43. King said that he was ill-equipped to understand the reports, and simply relied on his hope that others (such as Poundstone) would take care of any problems. Id. at 44. Although King did not know what the *Wyatt* standards consisted of, he was confident that other administrators were carrying them out. Id. at 51-52.

King was not familiar with the general admissions criteria at Eufaula. Id. at 78. King did not know students were supposed to be free from seclusion imposed for punishment. King took no action to stop improper seclusions.

In numerous respects, King failed to base his administrative decisions on professional judgments. He knew that Wyatt controlled Eufaula, but did not know even generally what Wyatt required.[8] He received patient Advocate Reports and reviewed them for information, yet failed to take any steps toward insuring that violence was being eradicated, or at least appropriately investigated at Eufaula.[9] See FY 1991-93 Annual Monitoring Report, Pltf's # 7. The advocacy report documents incidents of abuse, and is consistent with the affidavits of Kirby and Fowler. King received a copy of the report, reviewed it, but took no action.

King did view his job as managing the budget, upon the recommendation of Poundstone, such that it was his responsibility to ensure that money was spent wisely. However, King was unsure whether he even considered the *Wyatt* orders while making the budget. King depo. p. 79-80. Thus, it appears that King had no real understanding of the clinical needs of Eufaula. He seems to acknowledge that he had no idea whether his budget assisted in the improvement of services at Eufaula or if it was woefully off the mark. As the Eleventh Circuit has aptly stated in the Eighth Amendment context, "[A]n official does

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[8]Because the commands of *Wyatt* are so clear, and meeting them are within King's responsibility, see *Cortes-Quinones v. Jimenez-Nettleship*, 842 F.2d 556, 561-62 (1st Cir.1988), the failure to meet these requirements may indicate an abdication of professional judgment and responsibility. See *Cortes*, 842 F.2d at 562-63 (existence of court decree weighs heavily against granting qualified immunity).

[9]See, e.g., *Howell v. Burden*, 12 F.3d 190 (11th Cir.1994) (finding that question of whether defendant became aware of contents of memorandum was jury question).

not insulate his potential liability for deliberately indifferent actions by instituting a policy of indifference." *Howell v. Evans*, 922 F.2d 712, 723 (11th Cir.1991).

In addition, Dr. Mazick stated that Eufaula's services could be improved through an increased budget. Some defendants have conclusorily pleaded that they could only perform within the bounds set by their limited resources, and that resource limitation may have required a substandard performance. It is possible that a jury could find King liable for the inadequacy of those resources. *K.H. Through Murphy v. Morgan*, 914 F.2d 846, 854 (7th Cir.1990). Indeed, a jury could reasonably find that King acted with deliberate indifference, or in the absence of professional judgment, in relation to David's constitutional rights; that a reasonable person in King's position would have known that his conduct constituted the absence of professional judgment; and that this conduct was causally related to the grossly inadequate care provided to David. See *Greason*, 891 F.2d at 839.

D. Pendent State Claims

Plaintiff alleges several pendent state claims predicated upon the theories of negligence, wantonness, and respondeat superior. All defendants deny that they acted negligently. All defendants argue that they are entitled to discretionary function or substantive governmental immunity from tort liability.

The Supreme Court of Alabama has adopted the rule of immunity propounded by the Restatement (Second) of Torts, Sec. 895D (1977), which states that a "public officer acting within the general scope of his authority is not subject to tort liability for an administrative act or omission if ... he is immune because engaged in the exercise of a discretionary function." See *Smith v. King*, 615 So.2d 69, 72 (Ala.1993); *Barnes v. Dale*, 530 So.2d 770,

783 (Ala.1988). While it is true that the court's determination of the existence of substantive immunity "must necessarily turn on the circumstances of each case," *Smith v. Arnold*, 564 So.2d 873, 876 (Ala.1990), the Supreme Court of Alabama has recognized that "the very nature of the mental health profession involves discretion and difficult decision-making." Id. at 875. This statement carries particular weight in this case. Because the acts of none of the defendants could be characterized as purely ministerial, and because the actions of all the defendants (including the actions of Dykes, King, and Poundstone who were not trained to make clinical determinations), required the exercise of discretion and difficult decision-making, id. at 875-76, defendants' motions for summary judgment on the pendent state claims are due to be granted.

III. CONCLUSION

Qualified immunity will be denied for all defendants as to their Section 1983 liability. Substantive immunity will be granted as to all defendants as to their state liability. A separate order will be entered in accordance with this memorandum opinion.

APPENDIX I

Michael Leroy DOLIHITE, Individually and as Father and Next Friend of David Michael Dolihite; Joyce Mary Dolihite, Individually, Plaintiffs-Appellees,

v.

Robert MAUGHON, M.D., Deceased, By and Through Mary Fay VIDEON, as Executrix of the Estate of Robert Maughon, M.D.; Royce G. King, Individually; R. Emmett Poundstone, III, Individually; Anthony R. Dykes, Individually; Bradley Mazick, Individually; Karen Jurls, individually; Andrew McBride, Individually; Chester Jenkins, M.D.; Medical Money Management, Inc., Defendants-Appellants,
The Alabama Department of Mental Health; Eufaula Adolescent Center; Neuropsychiatry Associates, P.C.; Medical Management, Inc., Defendants.

No. 94-6343

United States Court of Appeals,
Eleventh Circuit.

[Filed January 23, 1996]

Appeal from the United States District Court for the Middle District of Alabama.

Affirmed in part and reversed in part.

Edmondson, Circuit Judge, dissented in part and concurred in result in part and filed opinion.

Before KRAVITCH, ANDERSON and EDMONDSON, Circuit Judges.

ANDERSON, Circuit Judge:

The appellants in this Sec. 1983 action argue that the district court erred in denying them summary judgment on the basis of qualified immunity. We affirm the district court's denial of summary judgment as to one of the appellants, Karen Jurls. We reverse the district court's order as to the remaining appellants; we hold that they are entitled to summary judgment on qualified immunity grounds.

On February 17, 1991, the Baldwin County Juvenile Court, having adjudged David Dolihite in need of supervision, ordered David committed to the Eufaula Adolescent Center ("Eufaula"), a facility of the Alabama Department of Mental Health and Mental Retardation ("ADMHMR"). David was not admitted to Eufaula until almost a year later, on January 13, 1992. He was fifteen years old. Approximately seventy days after his arrival at Eufaula, David hung himself. Although he was resuscitated, the injury he sustained during his suicide attempt left him severely brain-damaged.

David's parents, individually, and David's father, as his next friend ("the plaintiffs"), brought this Sec. 1983 action against various mental health professionals and administrators working for or under contract with ADMHMR. The individual defendants include: Bradley Mazick, Ph.D., Eufaula's clinical director; Karen Jurls, a Eufaula social worker; Andrew McBride, a licensed psychologist with Eufaula; Medical Money Management, Inc., a private corporation under contract with ADMHMR to provide psychiatric services to Eufaula; Drs. Robert Maughon[10] and Chester Jenkins, psychiatrists in

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[10]During the course of this litigation, Dr. Maughon died. After this event, the plaintiffs amended their complaint substituting the name of Mary Fay Videon, the executrix of his estate for Dr. Maughon's name. For the sake of simplicity and brevity we will refer to Dr.

the employ of Medical Money Management, Inc.; Anthony Dykes, Eufaula's director; Emmett Poundstone, ADMHMR Associate Commissioner for Mental Health; and Royce King, ADMHMR Commissioner.

The Dolihites allege that the defendants violated David's substantive rights under the due process clause of the Fourteenth Amendment set forth in *Youngberg v. Romeo*, 457 U.S. 307, 102 S.Ct. 2452, 73 L.Ed.2d 28 (1982),[11] i.e., his right to reasonably safe conditions of confinement, freedom from unreasonable bodily restraints, and such minimally adequate training as might be required to ensure safety and freedom from restraint. Id. 457 U.S. at 315-17, 102 S.Ct. at 2458-59. Discovery was completed. The defendants all moved for summary judgment on qualified immunity grounds. The district court denied their motions. *Dolihite v. Videon*, 847 F.Supp. 918 (M.D.Ala.1994). The defendants-appellants brought this interlocutory appeal. We have jurisdiction.[12] *Mitchell v.*

Maughon with the understanding that our holding applies to the now-named defendant, Mary Fay Videon.

[11]Although *Youngberg* involved a civilly committed mentally retarded person, this circuit has interpreted the *Youngberg* holding to apply to involuntarily, civilly committed mental patients. See, e.g., *Wooten v. Campbell*, 49 F.3d 696, 701 (11th Cir.1995) ("In Youngberg . . . , the Court extended the Estelle analysis holding that the substantive component of the Fourteenth Amendment's Due Process Clause requires the state to provide involuntarily committed mental patients with such services as are necessary to ensure their 'reasonable safety' from themselves and others."); *Rodgers v. Horsley*, 39 F.3d 308, 311 (11th Cir.1994) ("In Youngberg, the Court created the general legal principle that persons who are involuntarily committed to state mental institutions have a right to safe conditions, freedom from bodily restraint, and a right to minimal training.")

[12]Neither party challenges our jurisdiction under the recent Supreme Court opinion, *Johnson v. Jones*, — U.S. ——, 115 S.Ct. 2151, 132 L.Ed.2d 238 (1995). After careful review, we conclude that we have jurisdiction of this appeal. In *Johnson*, the only argument made on appeal by the public official seeking qualified immunity was that

Forsyth, 472 U.S. 511, 525-28, 105 S.Ct. 2806, 2815-16, 86 L.Ed.2d 411 (1985).

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the district court erred in concluding that there was a genuine issue of fact as to the official's involvement in the act. The act itself was a violation of clearly established law. The Court noted that this "evidence insufficiency" issue was different from the qualified immunity issue held to be immediately appealable in *Mitchell v. Forsyth*, 472 U.S. 511, 105 S.Ct. 2806, 86 L.Ed.2d 411 (1985). Several "countervailing considerations" persuaded the Court to decline extending the rule of immediate appealability to include "evidence insufficiency" issues. *Johnson*, — U.S. at ——, 115 S.Ct. at 2158.

In *Ratliff v. DeKalb County, Georgia*, 62 F.3d 338 (11th Cir.1995), this court addressed an issue similar to that in *Johnson v. Jones*. After accepting jurisdiction and resolving one claim for qualified immunity, the court addressed the public officials' claim of qualified immunity with respect to *Ratliff's* claim of gender discrimination. The public officials' only argument with respect to this claim of qualified immunity was that the record did not support any discriminatory intent on their part. Id. at 341. This court, noting that discriminatory intent was a necessary element of the underlying constitutional tort, declined to review the district court's determination that there was a genuine issue of fact as to whether appellants acted with discriminatory intent. Like the nonreviewable issue of fact in *Johnson*—i.e., whether the appealing public official was actually involved in the allegedly unconstitutional beating—the issue of fact on appeal in *Ratliff* was also a predicate factual element of the underlying constitutional tort. Also like *Johnson*, *Ratliff* involved an "evidence insufficiency" issue. See also, *Mastroianni v. Bowers*, 74 F.3d 236 (11th Cir.1996) ("Insofar as appeals from denials of summary judgment relate to 'factual disputes' or 'insufficiency of evidence' regarding plaintiff's claim, this court lacks appellate jurisdiction."); *Babb v. Lake City Community College*, 66 F.3d 270, 272 (11th Cir.1995) ("An order determining the existence or non-existence of a triable issue of fact—the sufficiency of the evidence—is not immediately appealable.").

Unlike *Johnson* and unlike *Ratliff*, the primary argument of each appealing public official in this case is that a reasonable public official could have believed that his or her actions were lawful, in light of clearly established law and the information possessed by each official. *Anderson v. Creighton*, 483 U.S. 635, 641, 107 S.Ct. 3034, 3040, 97 L.Ed.2d 523 (1987). This argument raises the core qualified im-

This opinion will set out the background facts and the relevant law and then address the entitlement of each

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munity issue and is, therefore, immediately appealable under *Mitchell v. Forsyth*, 472 U.S. 511, 105 S.Ct. 2806, 86 L.Ed.2d 411 (1985), and Johnson.

With respect to several subissues relating to several of the appellants, in order to evaluate the core qualified immunity issue presented by each appellant, we have identified precisely the relevant actions of the appellant and the relevant information possessed by each, of course, taking all reasonable inferences in favor of Dolihite. We are confident we have jurisdiction to do this. Cf. *Anderson v. Romero*, 72 F.3d 518, 523 (7th Cir.1995) ("[The issue] is whether in 1992 the constitutional right of a prisoner in [plaintiff's] position ... to be free from the specific acts that the defendants are alleged to have committed was clearly established. . . . . "). As is apparent from the above statement of the core qualified immunity issue, which statement was paraphrased from *Anderson*, 483 U.S. at 639, 107 S.Ct. at 3039, it is necessary to examine the precise actions of each appellant and the precise information possessed by each appellant in order to determine whether a reasonable public official could have believed that his or her actions were lawful, in light of clearly established law.

With respect to several of the mental health professionals in the instant case, to determine what law is clearly established, we must undertake a fact-sensitive examination of controlling case law, particularly *Greason v. Kemp*, 891 F.2d 829 (11th Cir.1990). We must then compare the facts in such case law (which have been determined to be in violation of the Constitution) with the precise actions and the precise knowledge of the actors in this case. For example, appellant Dr. Jenkins in the instant case is comparable to the psychiatrist in *Greason*. Dr. Jenkins' actions, and his knowledge at the time, must be identified precisely and then compared to the actions and knowledge of the psychiatrist in *Greason*. Only if the actions of Dr. Jenkins, in light of his knowledge, are materially similar to the actions and knowledge of the psychiatrist in *Greason* can it be said that he could not have thought that his actions were lawful. See *Lassiter v. Alabama A & M Univ., Bd. of Trustees*, 28 F.3d 1146, 1150 (11th Cir.1994) (en banc).

Thus, the identification of the actions and knowledge of each public official is part and parcel of the core qualified immunity issue which is immediately appealable. This inquiry is distinguished from

defendant to qualified immunity. In the summary judgment posture of this case, we take all reasonable factual

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the factual issues found to be unreviewable in *Johnson* and *Ratliff* in at least two respects. First, in both *Johnson* and *Ratliff*, the issue on appeal involved a predicate element of the underlying constitutional tort; by contrast, in this case, the issue we address is the core qualified immunity issue—i.e., whether a reasonable public official could have believed that his or her actions were lawful in light of clearly established law and the information possessed. Second, in both *Johnson* and *Ratliff*, the challenge on appeal involved the sufficiency of the evidence to create a genuine issue of fact; by contrast, in this case each appealing public official raises the core qualified immunity issue identified above.

Our conclusion that we have jurisdiction to identify the precise actions and the precise knowledge of each appellant is supported by the recent Eighth Circuit decision in *Reece v. Groose*, 60 F.3d 487 (8th Cir.1995). In *Reece*, the court held that it had jurisdiction "to examine the facts as they were known to the government official in order to determine whether clearly-established law would be violated by his actions." Id. at 489 (noting that Anderson required acceptance of such jurisdiction). Numerous other courts appear to have implicitly assumed such jurisdiction. See, e.g., *Lennon v. Miller*, 66 F.3d 416, 422-26 (2d Cir.1995) (undertaking review of "undisputed facts," i.e., record evidence concerning the facts underlying plaintiff's claim, to determine whether police officers' actions were objectively reasonable); *Rodriguez v. Phillips*, 66 F.3d 470, 480-81 (2d Cir.1995) (examining circumstances of prison to determine whether it was objectively reasonable for the official to believe plaintiff's administrative confinement did not violate his constitutional rights); *Buonocore v. Harris*, 65 F.3d 347, 357 (4th Cir.1995) (noting that, to determine whether actions violated clearly established law, the court must examine the facts as alleged by plaintiff); *Sanderfer v. Nichols*, 62 F.3d 151, 154-55 (6th Cir.1995) (appellate court itself identified the relevant actions of the public official, a nurse, in order to evaluate whether she was deliberately indifferent to a pretrial detainee's medial needs); *Prosser v. Ross*, 70 F.3d 1005, 1006 (8th Cir.1995) (noting that the district court failed to indicate what facts it believed to be in dispute and searching the record for undisputed facts, and also noting that the limitation imposed by Johnson "will sometimes make it difficult to determine whether jurisdiction exists because deciding whether an officer is entitled to qualified immunity requires a 'fact-

inferences in favor of the plaintiffs below. However, the plaintiffs bear the burden of proof. With respect to each

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intensive' inquiry"). We have found no contrary authority.

Even if we are incorrect in our conclusion that the identification of the precise acts and knowledge of each appealing public official is part and parcel of the core qualified immunity issue, we are satisfied that it would be "inextricably intertwined" with the core issue, and thus would be within our pendent appellate jurisdiction. See *Swint v. Chambers County Comm'n.*, 514 U.S. ——, ——, 115 S.Ct. 1203, 1212, 131 L.Ed.2d 60 (1995) (also suggesting that pendent issue jurisdiction may exist where review of the pendent issue is necessary to ensure a meaningful review of the qualified immunity issue); *Johnson*, — U.S. at ——, 115 S.Ct. at 2159 (suggesting that pendent issue jurisdiction of even evidence insufficiency issues may exist). When an appealing public official presents the core qualified immunity issue, we believe that we have pendent appellate jurisdiction of other issues presented by such official if the other issues are "inextricably intertwined" with the core issue. See *Blue v. Koren*, 72 F.3d 1075, 1084 n. 6 (2d Cir.1995) (finding that the district court's ruling that a genuine issue of material fact remained with respect to the qualified immunity issue is reviewable under the court's pendent jurisdiction where it is intertwined with the constitutional claim and is necessary for a meaningful review of whether the district court applied the appropriate standard). Every circuit to address Swint 's reference to "inextricably intertwined" issues has concluded that such pendent jurisdiction exists. See, e.g., *Kincade v. City of Blue Springs*, 64 F.3d 389, 394-95 (8th Cir.1995); *Kaluczky v. City of White Plains*, 57 F.3d 202, 206-07 (2d Cir.1995); *Moore v. City of Wynnewood*, 57 F.3d 924, 930 (10th Cir.1995). In this case, even if the identification of the precise actions and knowledge of each appellant is not part and parcel of the core issue, as we believe it is, the above discussion conclusively demonstrates that the issue is "inextricably intertwined." Indeed, it is absolutely necessary to identify precisely the public official's actions and knowledge in order to resolve the core qualified immunity issue.

Ordinarily, we might simply "take as given" the district court's identification of each appellant's actions and knowledge. See *Johnson*, — U.S. at ——, 115 S.Ct. at 2159. However, with respect to the appellants in this case other than Jurls, we cannot conclude that the district court's identification of the actions and knowledge of each appellant was adequate. The Supreme Court in *Johnson* ac-

appellant, we have taken the relevant facts as identified by the district court and supplemented same as necessary to evaluate whether a reasonable public official could have believed that the actions of each appellant were lawful, in light of the clearly established law and in light of the information possessed by each appellant.

I. BACKGROUND FACTS

In February of 1991, the Baldwin County Juvenile Court adjudged David Dolihite in need of supervision because of David's problematic behavior at home and at school.[13] The court placed David in the custody of

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knowledged that in such a circumstance, an appellate court appropriately would have to undertake such identification. Id. Cf. *Rivera v. Senkowski*, 62 F.3d 80, 84-85 (2d Cir.1995) (examining record evidence where district court failed to articulate an adequate factual basis upon which it relied in declining to hold defendants immune from suit). With respect to appellant Jurls, our identification of her actions and knowledge is consistent with that of the district court; in other instances, we have made the identification more precise. Especially in the context of health care professionals providing medical care, the core qualified immunity inquiry is exceedingly fact sensitive on both sides of the coin. On the side of the coin involving the determination of clearly established law, it is necessary to identify precisely the acts and knowledge of the comparable actor in controlling cases. On the side of the coin involving the actions of the appealing public official, it is necessary, as we have demonstrated, to identify precisely the actions and knowledge of the appealing public official. As we stated in *Lassiter v. Alabama A & M University, Bd. of Trustees*, 28 F.3d 1146, 1150 (11th Cir.1994) (en banc), a plaintiff cannot rely upon general propositions or abstractions to demonstrate a violation of clearly established law; rather, the facts of the controlling precedent must be materially similar to those in the instant case. Id.

[13]At the time of the adjudication David had no juvenile convictions or history of drug or alcohol abuse. But by March he had been adjudged delinquent because he drew a knife on someone at the Boys Home in Robertsdale where he was sent while waiting to go to

ADMHMR and instructed the Department to return the child to the custody of his parents after he successfully completed the Eufaula program. David continued to reside, for the most part, with his parents until he was admitted to Eufaula on January 13, 1992.[14]

By January 23, 1992, David had been evaluated by three of the defendants—Dr. Maughon, a psychiatrist, Jurls, a social worker, and McBride, a psychologist.[15] It was determined through these evaluations that David had reported having attempted suicide,[16] had frequent suicidal ideations, was obsessed with writing poetry about death, and had some family history of suicide.[17] Appellees also contend that behavior described in David's Baldwin County Mental Health Department

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Eufaula. As a result of this incident he was again sent home. When he violated his probation by misbehaving at school, he was sent to the Hit Program, a Department of Youth Services Program in Montgomery, Alabama.

[14]The district court opinion indicates he was admitted on this date in 1991, but this appears to have been a typographical error.

[15]According to the record, appellant Mazick, the Eufaula clinical director, did not see David at this point.

[16]David told Jurls during her initial interview with him that he had attempted suicide ten times, that he made his first gesture in the fourth grade. He also described other attempts which had occurred within two years of his arrival at Eufaula. However, Jurls appears to have been skeptical about whether these attempts ever occurred or at least the nature of the attempts. "There is some question as to the actual pervasiveness of his [suicidal] thoughts and whether or not they appear to be more manipulative in nature or the result of significant clinical depression." At least one suicide threat was documented in his Baldwin County Mental Health Center Evaluation. David threatened suicide in March of 1991 in a poem he gave to a former girlfriend.

[17]Evidence in the record below indicates that David's grandmother committed suicide; however, the portion of David's Eufaula record which discusses the incident gives the impression that David's father's grandmother committed suicide.

evaluation could be construed as psychotic.[18] After his initial Eufaula evaluations, David was assessed as giving the "diagnostic impression of conduct disorder solitary aggressive type."

Ten days after David's arrival, the psychiatrist Dr. Jenkins and appellants McBride and Jurls became members of David's treatment team and, as such, signed David's master treatment plan. The treatment plan noted, among other things, that David suffered an active suicidal ideation and gesture problem, and it prescribed weekly, thirty-minute individual therapy sessions as well as a weekly forty-five-minute group session.

David exhibited self-destructive behavior while at Eufaula, including making suicidal threats and gestures. The following incidents occurred while David was at Eufaula and are documented in his Eufaula record unless otherwise indicated. On January 26, 1992, a nurse treated David for a deep puncture wound in his left wrist. David told the nurse that he "was going to cut his arm off and kill himself." David was placed on continuous observation, i.e., one-on-one observation, until the next day when Jurls, after completing a suicide assessment, moved him to close observation with one-hour checks.[19] On the

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[18]"He denies hallucinations at this time; however, in a very detached manner he describes looking in the mirror and seeing no reflection, seeing hands beckoning him and seeing the ghost of someone killed in a car wreck."

[19]The nurse apparently refused to give him medication for pain. In his Progress Notes Jurls wrote, "He claimed to be upset because Nursing Services did not provide treatment to a small puncture on his hand." In her suicide assessment of David conducted the following day, Jurls wrote: "I interviewed him on 1/27/92 and he appeared nondepressed and denied all suicidal ideation. He was verbal and animated. David did admit to being frustrated 1/26/92 10:30 pm and reported himself to having only a fleeting thought of suicide." She then moved him from continuous observation to close observation status and indicated that he was to be checked every hour.

suicide assessment form, Jurls noted that David's family did not have knowledge of David's past suicide attempts and that David's self-reported past gestures could not be confirmed. In David's Progress Notes, Jurls indicated that his reported suicidal thoughts were intermittent and without genuine intent.

In David's Progress Notes dated February 4, Jurls indicated that David had presented as extremely irrational during the previous week; she added that he was not out of touch with reality. On the afternoon of that day, David injured himself, creating an ulcer one centimeter in diameter on his left wrist. On February 13, a staff member reported that David wrote with a rock on the security screen over his window, "Oh, God I want to die, please take me or I'll commit suicide, Death, Suicide are the facts of life." David was given work restitution for his behavior but no additional therapeutic intervention, nor was he prescribed any medications, and no suicide assessment form was completed.[20]

On February 18, David was talking to himself and advised a nurse that he was talking "to a friend who told him what to do." On February 24, a staff member found David sitting on the floor in his room beside the figure of a star he had made of salt, cutting into a sore on the back of his wrist with his belt buckle, and allowing blood to drip onto the star. David told the staff member he was a devil-worshipper. David later that day wrote the staff member a note which indicated that he was not talking because the devil told him not to. On March 2, Jurls indicated in David's Progress Notes that he continued to enjoy the "shock value" of talking about suicide.

On March 8 at about 2:45 p.m., David cut his arm with a piece of metal. A staff member described the incident

[20]In Jurls' affidavit, she said that she performed a suicidal risk assessment and that David denied suicidal intent; however, there is no suicide assessment form in record with respect to this incident.

in David's Progress Notes: "When I arrived in the dorm he was standing in the bathroom and his left arm in the sink and the H_2O running, bleeding profusely from a cut to his left arm . . . ." David was taken to the emergency room. The cut required ten stitches and, as indicated by Jurls on David's suicide assessment form, was "fairly lethal due to vertical, wide cut and possibility of loss of excessive blood."

Around 4:45 p.m. the same day, David removed the sutures with his teeth. He told the Eufaula nurse that "he was going to kill himself and he was not going to have sutures put in" and "would remove them again." The nurse notified Dr. Jenkins about David's behavior. Over the phone, Dr. Jenkins prescribed 25 mg of Vistaril, a tranquilizer, and authorized the use of soft restraints. David was taken to the emergency room again. Jurls ordered David placed on continuous, i.e., constant, observation.

The next day Jurls completed a suicide assessment form on David. According to her notes, David denied suicidal intent, psychotic symptoms, and feelings of depression, but admitted self-injurious thoughts due to problems with peers. Although David's act of cutting himself and pulling his sutures out on March 8 was apparently determined to be a suicidal gesture or attempt, David was never seen by the psychiatrists or by Dr. Mazick nor was his treatment plan altered.[21] However, Jurls did

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[21]The affidavits of John Fowler and Billy Kirby, two of David's fellow Eufaula residents, also indicate that David was placed in seclusion for removing his sutures. His records indicate that he was secluded on March 9, but for failure to follow staff instructions. This is not the only incident for which David was secluded. Before his injury, David was sent to seclusion for a total of about 14 hours. It was apparently common practice at Eufaula to place a disruptive child in various forms of confinement, the milder version being dorm restriction which apparently meant that a child could not leave his dormi-

change his status to close observation with fifteen minute checks. Thereafter, his observation status was not changed again until the morning of March 24.

On March 15, David was secluded for "failure to follow rules, bleeding on walls and defecating on floor" in the time-out room. Once secluded, David continued to spit blood on the walls of the seclusion area.

On March 18, David stuck a pencil in his wound of March 8. He was again taken to the emergency room. Dr. Nixon, having treated David twice for his self- inflicted wound of March 8, requested David be evaluated by a psychiatrist. She wrote, "This child MUST be evaluated for anti-psychotic medication."[22] Jurls arranged for David to see Dr. Jenkins the next day.

Dr. Jenkins examined David on March 19. His notes in David's records state only the following: "This young man has been engaging in self-destructive behavior. Case reviewed with therapist and nurse. No current or past evidence of psychosis. MS: alert, oriented. Thought orderly. Affect indifferent. Memory and intellect intact. This difficulty seems behavioral. 'I think I messed up and may be a little bit crazy.'" There is no further indication in the record of what sort of assessment or examinations were completed to render this conclusion. David's treatment plan was not altered.

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tory or his dorm room except to attend classes or meals. Staff members could also place children in "time-out" which required children be confined in a particular room with a staff member checking on them every fifteen minutes. During his time at Eufaula, David was kept in time-out for approximately 70 hours. Seclusion was a more serious confinement, an extreme measure. Residents at Eufaula were apparently secluded individually in a building separate from the dormitories in one of three small rooms resemblant of bare jail cells with concrete floors, no furniture and no heat.

[22]Dr. Nixon noted in David's file that the March 18 incident was the third episode of self-mutilation which had come to her attention (including the removal of his March 8 stitches).

On Saturday, March 21, at 9:25 p.m., a staff member ordered David placed in seclusion after David destroyed facility property, threatened to cut himself with a piece of glass, and stated he was going to hurt himself if he got the chance.[23] While in seclusion, David beat his head on a wall, cursed loudly and was described as "totally out of control." The nurse on duty notified Dr. Maughon over the phone about David's behavior. Dr. Maughon instructed the nurse to administer 50 mg of Vistaril.

On Sunday, March 22, around 9:30 p.m., a mental health worker restricted David to the time-out room for destroying facility property.[24] According to the time-out records completed by mental health worker Allen Forte, David attempted to hang himself at 9:35 p.m. At 9:40 p.m., David was placed in seclusion. According to the defendants, Forte did not inform his shift supervisor of this incident, and the supervisor made no mention of it in his shift report.[25] There is no evidence that the hanging incident was mentioned in the shift report or that the clinical staff discussed it at their March 23 morning meeting.

On Tuesday, March 24, at 8:45 a.m., Jurls met with David. The Progress Notes indicate that the two of them discussed the previous weekend, specifically David's destruction of property and aggression. Neither in the Progress Notes themselves nor elsewhere in David's

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[23]The social worker on duty stated in David's Progress Notes that David was secluded for failing to follow staff's directions, threatening to do harm to himself, inciting a racial riot, and causing disruption to therapeutic environment.

[24]David had torn his closet door off its hinges and had knocked a hole in it. David told the worker that he had mood swings and felt like destroying something.

[25]The seclusion order indicated that the reasons for seclusion were David's physical aggression toward staff and his attempt to pull down a light fixture out of the ceiling. Samuel Denson, another mental health worker, rather than Allen Forte filled out the seclusion form.

record is it documented that Jurls knew about the weekend hanging attempt.[26] At that meeting she told David that the treatment team had met the previous morning and had decided to give David three days dorm restriction due to his behavior.

Her Progress Notes of March 24 also indicate that she had left instructions for the dorm staff to take David off close observation status on the morning of March 21 if March 20 had been uneventful. According to the Progress Notes, the dorm staff did not receive that order. Jurls renewed the order effective 1:20 p.m. on March 24.

Although David's records do not reveal that Jurls knew of the attempted hanging, the plaintiffs presented evidence that Jurls did know about the incident. A former Eufaula resident, John Fowler, signed an affidavit stating:

> I was in the time-out room on March 22, 1992. . . . David did try to hang himself. Ms. Jurls knew this because the next day, David and I talked with Ms. Jurls about it. Ms. Jurls spoke to both of us together about David trying to hang himself the night before. She knew David had tried to hang himself and she confronted us together about it and David admitted it in her presence and in my presence.

At 3:30 p.m. on March 24, after David went off close observation, Dr. Mazick and David had a short discussion[27] during which Dr. Mazick, apparently not cognizant

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[26]Jurls did write in David's Progress Notes of March 24 that he "continue[d] to resort to self-injurious behavior when angered or frustrated," but this might have referred to his behavior of March 19 (sticking the pencil in his wrist wound) or his behavior of March 21 (threatening to cut himself).

[27]According to Mazick's affidavit, David expressed an interest in speaking with Mazick in a seemingly chance encounter which occurred while David was in the hall outside Jurls' office.

of David's self-injurious behavior of the previous weekend, told David that he had not engaged in self-injurious behavior for several days and that he "did not see that [David] needed to remain on close observation."

Shortly afterwards, at 4:10 p.m., David was found hanging in his dormitory room closet by a shoestring. Emergency CPR was performed and David was resuscitated. He was then sent to Children's Hospital in Birmingham where it was determined that he suffered severe hypoxic brain damage. According to the district court, as of March, 1994, David remained in serious condition and functioned at the level of a three-year old.

The record reflects that during David's seventy days at Eufaula, he received three and one half hours of individual therapy with Jurls, a social worker, and six hours of group therapy. He was secluded for a period of fourteen hours, on dorm restriction for ten days, and in time-out for sixty-four hours. He was only seen by a psychiatrist twice, once upon admission and again on March 19. Dr. Mazick, the staff's Ph.D. psychologist, saw David briefly on March 24.

In the affidavits of Billy Kirby and John Fowler, as well as the testimony of Allen Forte, the plaintiffs presented evidence that at Eufaula there was gang activity, violence between residents, and abuse by the staff. John Fowler stated that David came to his room once to hide from gang members, that he told Jurls that gang members were threatening David, and that staff allowed gang members to mistreat other residents. He also claimed that the Eufaula staff hit and cursed at the residents,[28] that he had seen staff members hit David and another resident on numerous occasions, and that he personally told Dykes, Jurls, and Dr. Mazick about those incidents.

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[28]He also stated that once a staff member threw Billy Kirby, another resident, down the stairs.

He also asserted that staff members put the residents in time-out and seclusion for inappropriate reasons. In sworn testimony, Allen Forte, a former Eufaula employee, testified that he had seen supervisors strike children and that a twelve-year-old resident had been sexually abused twice by other residents.

The appellees also introduced the Eufaula FY 91-92 Advocacy Report as evidence that violence was rampant at Eufaula. That report indicated that thirty-three complaints were filed by residents. However, the report itself does not indicate the substance of more than a few of those complaints.[29] The report focuses instead on whether the investigations of those incidents were adequate. It concluded that they were not and that staff needed training on how to conduct proper investigations.

II. DISTRICT COURT'S DECISION

The district court, in denying the defendants' motions for summary judgment, stated that under the Eighth Amendment "[i]t is well settled that state governments possess 'a constitutional obligation to provide minimally

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[29]The report did recount the complaints behind some of the investigations. One resident reported being kicked in the ribs by another resident; another resident reported being hit in the face by a staff member; a third resident reported that a staff member had threatened to beat him up; a fourth investigation revealed that a resident might have been secluded as a means of punishment; and a fifth resident requested a referral to the nurse for treatment of an injury but was not seen until the following afternoon. Some investigation accounts were included as attachments to the Advocacy Report. In one, a resident reported a mental health worker hit him in his mouth; another indicated that a staff member had been cursing at the residents; a third concerned the incident in which a resident reported being kicked in the ribs by another resident; and, a fourth described an incident in which a resident reported a bruise on his right eye.

adequate medical care to those whom they are punishing by incarceration,'" *Dolihite v. Videon*, 847 F.Supp. 918, 926 (M.D.Ala.1994) (citing *Harris v. Thigpen*, 941 F.2d 1495, 1504 (11th Cir.1991)). The court noted that persons subjected to involuntary civil commitment are "'entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.'" Id. (citing *Youngberg v. Romeo*, 457 U.S. 307, 322, 102 S.Ct. 2452, 2461, 73 L.Ed.2d 28 (1982)). Thus, the court concluded that "Romeo made it clear that the Fourteenth Amendment due process requirements imposed on state officials who are entrusted to care for those who have been civilly committed to state institutions are considerably more rigorous than those imposed under the Eighth Amendment which are applicable to prisoners." 847 F.Supp. at 926.

The district court, in elucidating the law to be applied, set forth the rule established in *Romeo*, which held that "liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment." 457 U.S. at 323, 102 S.Ct. at 2462. The district court also cited the Eleventh Circuit cases *Waldrop v. Evans*, 871 F.2d 1030 (11th Cir.1989), and *Greason v. Kemp*, 891 F.2d 829 (11th Cir.1990), for the proposition that it is also well settled that officials in charge of the care of prison inmates are liable if put on notice of suicidal tendencies and fail to take reasonable precautions to prevent suicide. The court reasoned that this rule would necessarily apply to those trained to care for emotionally disturbed youths given the *Romeo* rule that due process rights of the civilly committed exceed the Eighth Amendment rights of the criminally incarcerated.

With respect to Jurls, a social worker and David's primary therapist, the district court focused on the Fowler affidavit which indicated that Jurls knew about the March 22 attempted suicide. The court also concluded that a jury could find that she did in fact read the portion of David's record which indicated that he had attempted to hang himself. Id. at 931-32. There being evidence that she knew of the suicide attempt of March 22, but failed to take steps to prevent David from attempting suicide, the district court determined that our precedent under *Greason* dictated a conclusion that her actions, taken in the light most favorable to the plaintiffs, would amount to deliberate indifference thus precluding summary judgment on qualified immunity grounds.

The district court denied the other defendants' motions for summary judgment. All the defendants here appeal that court's denial of their motion for summary judgment on qualified immunity grounds. We first set forth the appropriate qualified immunity analysis, and then we address the facts and law relevant to each individual appellant's case.

III. QUALIFIED IMMUNITY

The denial of qualified immunity is a question of law to be reviewed de novo. *Swint v. City of Wadley*, 51 F.3d 988 (11th Cir.1995). Because this is an appeal from the denial of a summary judgment motion, we must view the facts in the light most favorable to the plaintiff below. Id.

The qualified immunity analysis requires the court to determine whether a defendant violated clearly established constitutional law.[30] In *Harlow v. Fitzgerald*, 457

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[30]The first step of the analysis is to determine whether the officials were acting within their discretionary authority. *Sammons v. Taylor*, 967 F.2d 1533, 1539 (11th Cir.1992). That the defendants were acting within their discretionary authority is uncontested here.

U.S. 800, 818, 102 S.Ct. 2727, 2738, 73 L.Ed.2d 396 (1982), the Supreme Court explained that qualified immunity protects government officials performing discretionary functions from civil liability if their conduct violates no "clearly established statutory or constitutional rights of which a reasonable person would have known." Id. 457 U.S. at 818, 102 S.Ct. at 2738.

Qualified immunity is intended to give officials the ability to anticipate when their conduct may give rise to liability for damages. *Anderson v. Creighton*, 483 U.S. 635, 645, 107 S.Ct. 3034, 3042, 97 L.Ed.2d 523 (1987) ("Where [the qualified immunity] rule is applicable, officials can know that they will not be held personally liable as long as their actions are reasonable in light of current American law."). A plaintiff must establish more than broad legal truisms; he or she must demonstrate that the law fixed the contours of the right so clearly that a reasonable official would have understood his acts were unlawful. Id. at 639-640, 107 S.Ct. at 3039. Thus, "pre-existing law must dictate, that is, truly compel (not just suggest or allow or raise a question about), the conclusion for every like- situated, reasonable government agent that what defendant is doing violates federal law in the circumstances." *Lassiter v. Alabama A & M University, Bd. of Trustees*, 28 F.3d 1146, 1150 (11th Cir.1994) (en banc) (emphasis in the original). Moreover, officials need not "'be creative or imaginative in drawing analogies from previously decided cases.'" Id. at 1150 (citations omitted).

In *Anderson*, the Supreme Court described the qualified immunity analysis:

> The contours of the right must be sufficiently clear that a reasonable official would understand that what he is doing violates that right. This is not to say that an official action is protected by qualified immunity unless the very ac-

> tion in question has previously been held unlawful . . . but it is to say that in the light of pre-existing law the unlawfulness must be apparent.

483 U.S. at 640, 107 S.Ct. at 3039 (citations omitted).

Our courts have applied an objective reasonableness test to qualified immunity cases. In each circumstance, taking the facts known to the particular defendant, "the relevant question on a motion for summary judgment based on a defense of qualified immunity is whether a reasonable official could have believed his or her actions were lawful in light of clearly established law and the information possessed by the official at the time the conduct occurred." *Stewart v. Baldwin County Bd. of Educ.*, 908 F.2d 1499, 1503 (11th Cir.1990).

As a general matter, under *Romeo* the involuntarily civilly committed have liberty interests under the due process clause of the Fourteenth Amendment to safety, freedom from bodily restraint, and minimally adequate or reasonable training to further the ends of safety and freedom from restraint. 457 U.S. 307, 102 S.Ct. 2452, 73 L.Ed.2d 28 (1982). In addition, *Romeo* established that the involuntarily civilly committed were due a higher standard of care than the criminally committed; persons subjected to involuntary civil commitment are "entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish." Id. 457 U.S. at 322, 102 S.Ct. at 2461. Thus, it follows from *Romeo* that, all other circumstances being the same, actions of a mental health professional which would violate a prisoner's Eighth Amendment rights would also violate the due process rights of the involuntarily civilly committed.[31] An official

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[31]This holding does not require that public officials " 'be creative or imaginative in drawing analogies from previously decided cases' " in contravention to *Lassiter*. *Lassiter*, 28 F.3d at 1150. The conclusion is set forth in the plain language of *Romeo* and requires no analogies.

violates a prisoner's Eighth Amendment rights when the official is deliberately indifferent to the prisoner's serious medical needs. Estelle v. Gamble, 429 U.S. 97, 97 S.Ct. 285, 50 L.Ed.2d 251 (1976).

Although Romeo establishes that the involuntarily civilly committed have certain due process rights and that those rights are at least as extensive as the rights of the criminally institutionalized, that broad legal truism is insufficient to clearly establish the law for purposes of overcoming the appellants' qualified immunity claims in this case.[32] In determining whether the appellants in this case are entitled to qualified immunity, we must look at case law which sets forth the contours of the due process rights recognized in Romeo. Because, under Romeo, the due process rights at stake were at least equivalent to the comparable Eighth Amendment rights of the criminally committed, relevant case law in the Eighth Amendment context also serves to set forth the contours of the due process rights of the civilly committed.

We will address the facts relevant to each individual appellant in light of the relevant case law. We must determine whether that law clearly established the conclusion that a reasonable official at the time of the appellant's actions, knowing what the appellant knew, would have realized that those acts violated David's constitutional rights.

IV. THE APPELLANTS

A. Karen Juris

As David's primary therapist, Eufaula social worker Juris had the most frequent contact with David during his

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[32]Moreover, in Romeo, the Supreme Court did not decide whether the facts of that case would amount to a violation of the plaintiff's due process rights. Rather, the Supreme Court remanded the case for the lower courts to decide.

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time at Eufaula. She conducted a social history on him when he was admitted; she knew he reported having threatened and or attempted suicide before his arrival; she was on his treatment team; she was assigned to counsel him weekly for one half hour and to act as co- therapist during his weekly group therapy session;[33] she knew of David's self-injurious or suicidal behavior while at Eufaula; she conducted the two written suicide assessments in the record; she contacted Dr. Jenkins when it was recommended that David be evaluated for anti-psychotic medication; and, she maintained David on close observation status for much of his time at Eufaula because of the various incidents in which David threatened to commit suicide or exhibited suicidal gestures. Most significantly, for our purposes, the plaintiffs have produced evidence from which a fact finder could conclude that Jurls knew that David attempted to hang himself on March 22[34] but that she nevertheless took him off of close observation status without taking any other measures to protect his safety or otherwise meet his mental health care needs.

As the district court indicated, our precedent in *Greason*, 891 F.2d 829 (11th Cir.1990), is relevant. In *Greason*, an inmate committed suicide while in the Georgia Diagnostic and Classification Center ("GDCC"), a Georgia Department of Corrections facility where the decedent was being held. The decedent's family brought a Sec. 1983 action, alleging that the mental health professionals and administrators at the facility were deliberately indifferent to the decedent's mental health needs in vio-

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[33]The record indicates that David's therapy did not occur as often as prescribed.

[34]There is a factual dispute as to whether or not David attempted to hang himself on March 22, and also with respect to Jurls' knowledge thereof. In the summary judgment posture of this case, we take the reasonable factual inferences in favor of the plaintiffs.

lation of the Eighth Amendment. Calvin Brown, the mental health team leader in charge of the inmate's (Greason's) care and one of the defendants in that case, was denied summary judgment on qualified immunity grounds. Brown knew that while at the facility Greason had been experiencing feelings of despair and thoughts of suicide and on one occasion had attempted to kill himself by tying something around his throat. This incident had been reported to Brown well before Greason's final suicide, not only by two inmates, but also by Greason's parents who on a visit to the facility asked Brown for his help with respect to the problem. Id. at 832 & n. 8. Nevertheless, Brown did not notify the staff psychiatrist or put Greason on suicide watch. The court concluded such conduct violated the decedent's Eighth Amendment rights:

> The question here is a narrow one: whether Brown's failure to monitor Greason after having been warned by Greason's parents and two inmates that Greason had tried to commit suicide constituted deliberate indifference.
>
> Where prison personnel directly responsible for inmate care have knowledge that an inmate has attempted, or even threatened, suicide, their failure to take steps to prevent that inmate from committing suicide can amount to deliberate indifference.

Id. at 835-36 (footnotes omitted). The court affirmed the district court's denial of Brown's motion for summary judgment on qualified immunity grounds, concluding "that a reasonable person in Brown's position would have known that his provision of care constituted deliberate indifference to Greason's eighth amendment rights . . . " Id. at 836.

The situation in this case is comparable to that of Brown in *Greason*. Jurls admits that she knew of David's history of mental illness, i.e., his suicide threats and attempts or gestures and his self-injurious behavior. If a jury found that she knew of his self-injurious behavior over the weekend beginning March 21, especially the attempted hanging on March 22, Jurls' decision to take David off of close observation on March 24 presents a situation comparable to Brown's behavior in Greason. Like Brown in *Greason*, Jurls failed to notify any of the psychiatrists or psychologists available to her and failed even to continue the protective measures already in place for David. Rather than protecting David or seeking professional guidance, Jurls' alleged behavior actually put David at greater risk of suicide. Thus, her decision is comparable to the decision which was held to constitute deliberate indifference in *Greason*.

Because the constitutional violation on such facts was clearly established in *Greason*, we conclude that plaintiffs-appellees have adduced sufficient evidence to support findings of fact which would constitute a violation by Jurls of clearly established constitutional rights. Thus, we affirm the district court's denial of summary judgment with respect to Jurls.

B. Andrew McBride

McBride, a staff psychologist at Eufaula, conducted one of David's initial evaluations and was on David's treatment team. His primary contact with David appears to have been as co-facilitator of David's group therapy sessions. McBride knew about David's history and many of the incidents which occurred while David was at Eufaula. The plaintiffs contend that McBride should be liable because he failed to take action after David's hanging attempt. However, the plaintiffs do not argue that McBride knew about David's March 22 hanging at-

tempt.[35] Rather, they argue that his failure to apprise himself of that information and to take action to prevent David from doing further injury to himself in light of that information constituted a constitutional violation.

The fact that McBride did not know about the hanging attempt sets his situation apart from Jurls'. McBride indicated that during Monday morning community meetings, the residential staff would report to clinical staff what of importance happened over the weekend. The plaintiffs allege that McBride saw the seclusion report. McBride, however, testified that he read the March 23 Progress Note but was only "informed" of a seclusion report. The Progress Notes recorded on March 23 indicated that on both March 21 and March 22 David was secluded, in part, for attempting to do harm to himself. This information is substantially the same as that which would have been available had he read the March 21 and March 22 seclusion reports. Thus, there is no evidence McBride was apprised of the hanging attempt, but he was on notice that David's self-injurious tendencies persisted through the weekend.

McBride's failure to inquire further and seek out the record for closer inspection should be considered in light of the fact that the clinical staff not on duty on weekends apparently regularly relied on the residential staff to report important incidents occurring on weekends and that neither the residential staff nor the portion of the record McBride reviewed indicated that

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[35]The district court's opinion is not clear, but it may have thought that McBride knew of the March 22 hanging attempt. 847 F.Supp. at 933 ("McBride did not perform a suicide assessment on David at that time, despite his awareness of Mr. Forte's report, McBride depo. at 28-32 . . . . "). However, our careful review of the deposition reveals no suggestion that McBride knew of the hanging attempt; indeed, McBride expressly disavows such knowledge. Nor is there other evidence that McBride knew.

David's threats to do harm to himself involved a hanging attempt. Also, the appellees do not assert that McBride knew about or took part in the decision to take David off close observation.[36] Without knowledge of the March 22 hanging attempt and with no apparent role in the decision to take David off close observation, we cannot conclude McBride's failure to take action after the weekend of March 21-22 constituted a violation of clearly established constitutional law under *Greason*[37] or other relevant Eighth or Fourteenth Amendment case law.

Although the plaintiffs presented as evidence an affidavit from an expert which stated that Andrew McBride "failed to meet the basic professional standards in the evaluation, assessment, and treatment" of David, the affidavit does not with any specificity indicate how McBride's evaluation and treatment of David failed to meet basic professional standards. A conclusory affidavit of this nature provides little support for the appellees' claim.

The Dolihites also allege that McBride should be liable because he failed to recommend that David be transferred to another facility even though he considered David actively suicidal and knew that Eufaula's policies did not authorize admitting actively suicidal patients. See Eufaula Adolescent Center Policy No. 3.47, Admission Criteria, # 2.E. However, no cases hold that a govern-

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[36]The fact that he did take part in putting David on dorm restriction does not indicate that he took part in the decision to take David off of close observation status. There is no indication in the evidence presented and plaintiffs do not allege that dorm restriction meant that a resident was automatically taken off close observation.

[37]The actions of Calvin Brown, the mental health team leader in *Greason*, can be distinguished from McBride's actions here. Brown took no measures to protect Greason or to seek appropriate help for Greason. The evidence in the record indicates that, as far as McBride knew, measures were being taken to protect David from himself, i.e., David was on close observation status and was being monitored every fifteen minutes.

ment official's violation of facility or department policy, without more, constitutes a constitutional violation. See, e.g., *Edwards v. Gilbert*, 867 F.2d 1271, 1276-77 (11th Cir.1989), modified, reh'g denied, *Edwards v. Okaloosa County*, 23 F.3d 358 (11th Cir.1994). Our case law does indicate that failing to transfer or accommodate the serious health needs of a prisoner could amount to a constitutional violation. In *Howell v. Evans*, 922 F.2d 712, 722-23 (11th Cir.1991), vacated as moot, 931 F.2d 711 (11th Cir.1991), reinstated by unpublished order as noted, 12 F.3d 190 (11th Cir.1994), this court concluded that a superintendent of a correctional facility was not entitled to qualified immunity under the following facts. The superintendent knew that an inmate had an urgent need for a particular type of medical personnel. After the denial of the superintendent's recommendation that the inmate be medically released, the superintendent failed to seek the needed personnel on his own initiative. Instead, he relied on the medical administrator to seek funding for the personnel through the regular budgetary process.

The case at bar is different from *Howell*. In *Howell*, the facility medical staff indicated to the superintendent that the "prisoner could not be treated under the then current conditions" of the facility. In the case before us, the record indicates that the Eufaula staff could have treated David. Even the plaintiffs' experts do not contend that Eufaula was not equipped to treat David. Rather, the expert affidavits simply point to deficiencies in the actions of Eufaula's professional personnel.[38]

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[38]For instance, Dr. Abraham Halpern, the plaintiffs' psychiatric expert, concludes that David should have received psychiatric medication and more intensive therapy. Both options were apparently available at Eufaula.

We conclude that the facts adduced by appellees fail to show that defendant McBride violated clearly-established constitutional law.

C. Medical Money Management, Dr. Chester Jenkins, and Dr. Robert Maughon

1. The Medical Money Management Contract

Drs. Jenkins and Maughon were psychiatrists who, as employees of Medical Money Management, Inc., were under contract with Eufaula to: provide psychiatric services on a consulting basis, admit residents, write initial treatment plans, determine patients' admitting diagnoses, prescribe medications, perform medication reviews, examine residents before discharge, provide expert testimony in court, and provide twenty-four hour call coverage. As physicians under contract with the state, the psychiatrists were state actors subject to liability under Sec. 1983. See *West v. Atkins*, 487 U.S. 42, 55-58, 108 S.Ct. 2250, 2259-60, 101 L.Ed.2d 40 (1988); *Ancata v. Prison Health Services, Inc.*, 769 F.2d 700, 703 (11th Cir.1985). Because they are individuals subject to liability under Sec. 1983, the psychiatrists are also entitled to raise qualified immunity as a defense to liability.

The district court concluded that the psychiatrists, as members of David's treatment team, had broad authority and implicitly broad responsibility notwithstanding their allegedly limited duties under the Medical Money Management contract. *Dolihite v. Videon*, 847 F.Supp. at 930. However, only Dr. Jenkins was on David's treatment team, and the fact that Dr. Jenkins was on David's treatment team does not, in and of itself, indicate that he had broader responsibilities than those set forth under the contract. Significantly, appellees have not adduced evidence that the psychiatrists had a duty to follow up on every patient at Eufaula. The contract indicates that after

a resident was admitted, the psychiatrists were only obligated to follow up on patients in order to perform medication reviews.[39]

The psychiatrists did have a duty to do intake evaluations, initial diagnoses and initial treatment plans and to provide psychiatric services when consulted. Thus it is incumbent upon us to examine how each psychiatrist performed when called upon to fulfill these duties.

2. Dr. Chester Jenkins

a. Facts Relevant to Dr. Jenkins

Dr. Jenkins was the psychiatrist assigned to David's treatment team. Although he did not conduct David's initial evaluation or render the initial diagnosis, Dr. Jenkins signed David's treatment plan in late January, 1992. The plan listed suicidal ideations and gestures among David's primary problems and recorded Dr. Maughon's diagnosis of "conduct disorder solitary aggressive type." David next came to the notice of Dr. Jenkins on March 8, when a Eufaula staff member notified him by phone that David had purposely cut his arm, stated that he "want[ed] to commit suicide," and then purposefully removed the stitches from the self-inflicted wound. Over the phone Dr. Jenkins authorized the use of Vistaril, a tranquilizer, and soft restraints, if necessary. Dr. Jenkins did not follow up on the incident.

Then on March 18, after David stuck a pencil in the wound of March 8, Eufaula staff again contacted Dr. Jenkins about David. That day Dr. Nixon, the emergency room doctor who had also treated David on March 8, indicated emphatically in David's medical records that

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[39]Although both Drs. Maughon and Jenkins prescribed Vistaril, a tranquilizer, for David, the plaintiffs do not contend that that prescription triggered the duty to follow-up.

David needed a psychiatric examination.[40] The next day, March 19, was the first day and the only time that Dr. Jenkins either saw David or reviewed David's record. According to Dr. Jenkins, he spent about one half hour with David. He conducted a "mental status examination." Dr. Jenkins' notes of this examination, as recorded in David's record, are cursory. Dr. Jenkins wrote that he had reviewed David's case with David's nurse and therapist, that David had been engaging in self-destructive behavior, that there was no current or past evidence of psychosis, that David was "alert" and "oriented," that his thought was orderly, his affect indifferent, and his memory and intellect intact. Dr. Jenkins concluded, "This difficulty seems to be behavioral."

Although the scope of Dr. Jenkins' March 19 "mental status examination" was not well-developed by the plaintiffs, it is apparent from Dr. Jenkins' deposition that he formed the opinion that there was no evidence of clinical depression, delusions, or psychotic behavior. It was Dr. Jenkins' opinion that David was exhibiting "non-suicidal self-destructive behavior," i.e., behavior that was harmful but not life-threatening and behavior for which there was some explanation. The explanation was that such behavior was impulsive and related to things about which David was angry or frustrated—i.e., David was using such behavior in a manipulative fashion. Dr. Jenkins' ultimate opinion was that there was not a need for psychotropic drugs and that David's problem was behavioral.

b. Allegations Against Dr. Jenkins

The plaintiffs do not allege that Dr. Jenkins took part in the decision to take David off close observation on March 24 or that Dr. Jenkins had any contacts with David

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[40]She wrote: "MUST be evaluated by Psychiatrist for antipsychotic medication . . . ."

between the March 19 evaluation and David's March 24 suicide attempt. The plaintiffs do allege that Dr. Jenkins failed to recognize David's obvious signs of clinical depression and bipolar disorder and to diagnose him accordingly. They contend that David's history of suicide threats and his family history of suicide, his increasing episodes of self-mutilation and mood swings should have led to that diagnosis. They assert that Dr. Jenkins should have prescribed intense and lengthy one-on-one therapy and antidepressant medication for David and that the failure to do so was a total departure from professional judgment.

The plaintiffs contend that Dr. Jenkins had the duty to make such a diagnosis and recommend such treatment when he was consulted on March 8 and then again when he was consulted on March 19. They also assert that Dr. Jenkins failed to exercise professional judgment when he did not see David on March 8. They argue that on March 19, when he did see David, he failed to do an in-depth evaluation or even an in-depth review of the record.[41] They argue that an in-depth review of the record would have revealed evidence of David's serious mental illness illustrated by David's March 15 episode of bleeding and defecating on the walls of the time-out room as well as other unspecified instances indicating serious mental illness. The plaintiffs also cite Dr. Jenkins' cursory notes on the examination as evidence that Dr. Jenkins did not do any testing or in-depth evaluation. Finally, the plaintiffs contend that Dr. Jenkins also failed to have the Ph.D.

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[41]Apparently, both the plaintiffs and Dr. Halpern in his expert affidavit are confused about which psychiatrist was involved in the March 19 and March 21 incidents. The defendants note that Dr. Jenkins, not Dr. Maughon, evaluated David on March 19 and Dr. Maughon, not Dr. Jenkins, prescribed the Vistaril tranquilizer on March 21.

psychologist, Dr. Mazick, see David for more in-depth testing.

c. Expert Testimony Against Dr. Jenkins

The plaintiffs presented expert medical testimony. Our circuit has indicated that the testimony of medical experts can aid the court in determining whether qualified immunity is appropriate where allegations hinge upon the appropriateness of the actions of medical professionals, including mental health professionals. See *Howell v. Evans*, 922 F.2d 712, 722-23 (11th Cir.1991), vacated as moot, 931 F.2d 711 (11th Cir.1991), reinstated by unpublished order as noted, 12 F.3d 190 (11th Cir.1994); *Greason v. Kemp*, 891 F.2d 829 (11th Cir.1990); *Waldrop v. Evans*, 871 F.2d 1030 (11th Cir.1989); *Rogers v. Evans*, 792 F.2d 1052 (11th Cir.1986). Such expert medical testimony, making reference to specific deficiencies in a defendant's treatment and specific medically accepted standards might, in conjunction with the specific facts of a case, persuade a court that the medical defendant's actions in the case were clearly as great a departure from appropriate medical standards as previous departures found unconstitutional in prior cases—i.e., might persuade a court that a reasonable professional in defendant's shoes would have known that his challenged actions (or inaction) violated plaintiff's constitutional rights.[42]

The plaintiffs presented the affidavit of Dr. Abraham L. Halpern, a certified and practicing psychiatrist. His

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[42]However, an expert opinion which is merely conclusory, even if couched in the language of the relevant legal standard, will be of little assistance to a court. See, e.g., *Rogers v. Evans*, 792 F.2d 1052, 1062 n. 9 (11th Cir.1986) (approving lower court's order striking affidavit of medical expert where the affidavit was "phrased in conclusory terms without citing facts" and concluding that the affidavit was "defective to create a factual dispute").

affidavit states that the psychiatrists' treatment of David was "a total departure from professional judgment, practice or standards such that it cannot be said that their treatment of David was based on accepted professional judgment." However, Dr. Halpern's affidavit suffers from several flaws.

First, Dr. Halpern was not careful to discuss Dr. Maughon and Dr. Jenkins separately. Instead, Halpern often referred to "their treatment" of David. And, when he did discuss them individually, Dr. Halpern confused the two doctors' roles in their treatment of David; his affidavit indicates that Dr. Maughon examined David on March 19 and Dr. Jenkins prescribed Vistaril for David on March 21, when in fact it was Dr. Jenkins who performed the examination on March 19 and Dr. Maughon who received the call on March 21. Also, Dr. Halpern assumes that the psychiatrists under contract with Eufaula had a duty to manage and follow up on each patient. As discussed, supra, Medical Money Management's contract did not call for that[43] nor does any other part of the record indicate that the consulting arrangement or accepted medical standards required monitoring and follow-up on any patients aside from those patients receiving medication.[44] The terms of the agreement indicated that the psychiatrists could depend on the staff mental health professionals to bring to their attention problems indicating a need for psychiatric intervention. Finally, Dr. Halpern's affidavit was not help-

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[43]Rather, the contract required Drs. Maughon and Jenkins to conduct the initial evaluation, to prescribe medication, to follow up on patients receiving medication, to be available for consultation, and to consult on an as-needed basis.

[44]There is another error in Dr. Halpern's affidavit—as part of his consideration of the March 19 events, Dr. Halpern assumes that the psychiatrist should have called the emergency room doctor. There is no substantiation for this claim in his affidavit or in relevant case law.

ful in establishing the degree to which Dr. Jenkins had allegedly departed from accepted medical standards.

Dr. Halpern's affidavit does refer to three incidents which he suggests indicated a need for more intensive intervention—the February 18 incident in which David was found talking to himself, the March 8 incident when David cut himself and removed the sutures, and the March 15 incident when David was bleeding on the walls and defecating on the floor of the time-out room. Dr. Halpern expressly labels only one of these incidents as psychotic behavior. He does not state why these incidents are so serious as to require medication or more intensive therapy nor does he cite authority for his conclusory suggestion that any doctor would recognize these incidents as calling for more intrusive intervention. In the last analysis, Dr. Halpern's affidavit is conclusory and as such is of relatively little value in our interpretation of the facts of this case. Thus, we are essentially left with little help from the expert in comparing the facts of this case with binding precedent which sets forth the contours of our law in this area.

This is not to say that Dr. Halpern's conclusions are wrong. Rather it is to say that his affidavit does not aid us in our qualified immunity analysis. His affidavit is not the kind of tool which indicates with any specificity the degree to which the doctor here strayed from the realm of accepted professional judgment. The fact that Dr. Halpern used the phrase "total departure from professional judgment, practice or standards, such that it cannot be said that their treatment of David was based on accepted professional judgment of psychiatric practice" does not foreclose summary judgment when qualified immunity has been properly raised. The affidavit must help the court to discern whether the purported departure was so egregious that, in light of the reported cases, a

reasonable professional would have recognized that his behavior amounted to a constitutional violation.

d. Application of Prior Case Law

Our analysis here will focus first on the plaintiffs' assertion that Dr. Jenkins failed to adequately assess and treat David after the March 18 incident when David stuck a pencil in his March 8 self-inflicted wound. Dr. Jenkins evaluated David on March 19, the day following Dr. Nixon's note in David's record indicating the need for a psychiatric evaluation for anti-psychotic medication.

Relevant to our inquiry into Dr. Jenkins' behavior on March 19 is the fact that Dr. Jenkins indicates that he reviewed David's record prior to examining him. Thus, taking the facts in the light most favorable to the plaintiffs, Dr. Jenkins would have known of:

1. David's previous suicidal threats and gestures;

2. David's grandmother's suicide;

3. Dr. Maughon's initial diagnosis of David, "conduct disorder, solitary aggressive type";

4. David's January 26, 1992, deep possibly self-inflicted puncture wound to his left wrist and his statement that he was going to "cut his arm off and kill himself";

5. The February 2, 1992, incident when David wrote, "Oh, God I want to die, please take me or I'll commit suicide, Death, Suicide are the facts of life." on the security screen in his dormitory room;

6. The February 4, 1992, self-inflicted injury to the left wrist and the Progress Note of the same day indicating that David had been presenting as irrational;

7. The February 18, 1992, incident when David was talking to himself and telling a staff nurse that he was talking "to a friend who told him what to do";

8. The February 24, 1992, incident when David performed some allegedly Satanic ritual in his room, in-

flicted further injury to left wrist, after which he told a mental health worker that the devil told him not to speak;

9. The March 8, 1992, incident when David cut his arm with a piece of metal in an apparently suicidal gesture, and after which he pulled out the stitches and refused new stitches;

10. The March 15, 1992, incident when David bled on the walls and defecated on the floor of the time out room; and

11. The March 18, 1992, incident when David re-injured his left wrist by sticking pencil in it and was again sent to the emergency room.

In addition to these facts, Dr. Jenkins would have known that Dr. Maughon had not identified a psychosis, that David's suicidal threats and gesture problem were supposedly being addressed during his weekly therapy sessions, and that David's family could not confirm that he had attempted suicide before coming to Eufaula. The record also indicates that Jurls questioned whether David experienced genuine suicidal intent,[45] and that whenever he was explicitly asked about it David consistently denied having suicidal intent, a specific suicidal plan, or being depressed.

Having set forth the extent of Dr. Jenkins' knowledge of David at the time of the challenged treatment, we now turn to this circuit's prior cases to determine whether or not the departure in this case is as egregious as those

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[45]For instance, at one point she considered his threats to be for "shock value" and at another she questioned "the actual pervasiveness of his thoughts and whether or not they appaer to be more manipulative in nature." In the first suicide assessment, Jurls noted that David's family did not have knowledge of David's past suicide attempts and that David's self-reported past gestures could not be confirmed.

cases, or more so. It is clear that Dr. Jenkins' departure in this case is not as egregious a departure as that of the psychiatrist in *Greason v. Kemp*, 891 F.2d 829 (11th Cir.1990). In that case, the psychiatrist—without conducting a mental status exam and without reading an inmate's record—discontinued the inmate's antidepressant medication. Before entering prison, the inmate in Greason had been diagnosed as schizophrenic with suicidal tendencies and had been treated at a county mental health center with anti-depressant medication because he had contemplated suicide. Both the inmate's former therapist at the county facility as well as a psychiatrist from the Georgia Department of Human Resources sent letters or reports recommending that the inmate be maintained on his anti-depressant medication. Both of these letters were in the inmate's file. The psychiatrist in Greason discontinued the medication without instructing that the inmate be monitored for the adverse effects of discontinuing the medication.

Similarly, the instant facts are not as egregious as those presented in *Rogers v. Evans*, 792 F.2d 1052 (11th Cir.1986).[46] There the court concluded that deliberate indifference to medical needs might be established under the circumstances—i.e., a reasonable jury could find that in response to the justified criticism of past inappropriate medical care, the psychiatrist had simply withdrawn medical care altogether. Id. at 1061. The court also considered the fact that the defendant-psychiatrist had treated the inmate's psychotic symptoms with placebos and the fact that the doctor had used Prolixin, a treatment which was arguably grossly incompetent.

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[46]This case did not address the qualified immunity issue. Nevertheless, it sets forth binding precedent and as such serves to elucidate the contours of the law in this area.

A third case, *Waldrop v. Evans*, 871 F.2d 1030 (11th Cir.1989), preceded *Greason* and involved the same facility and the same psychiatrist. In that case an inmate pled guilty but mentally ill to armed robbery. Id. at 1032. When the inmate arrived at the Georgia Diagnostic and Classification Center, a Georgia Department of Corrections facility, in October of 1984, he had been diagnosed as manic depressive and was taking lithium. Id. On October 18, 1984, he was evaluated by the defendant psychiatrist who concluded that his psychiatric problems were in remission and withdrew the drugs. Id. at 1034. A staff physician recommended another interview because Waldrop was suffering from insomnia, nightmares, and nausea. The psychiatrist saw him again on October 27, 1984, but did not place him on medication. On November 1, 1984, Waldrop slashed his forearm, although the psychiatrist was not notified at the time. Id. at 1032, 1034. On November 4, 1984, Waldrop gouged his left eye out and was taken to the hospital. Id. at 1032. Upon his return from the hospital on November 8, 1984, the psychiatrist examined Waldrop and placed him on two drugs but not on lithium, the antidepressant drug he had previously been prescribed. Id. at 1034. The psychiatrist also ordered no emergency measures to protect Waldrop. Id. Later, at another facility, the inmate cut his scrotum, losing both testicles, and so severely damaged his right eye that he lost his sight in it. Id. at 1032. Pursuant to expert medical opinion in evidence, the court held that a jury could reasonably find facts which would rise to the level of a violation of clearly established law.

It is fair to say that the self-injurious actions preceding David's final injury in this case are not comparable to those in Waldrop; Waldrop's gouging out his left eye clearly is a more serious incident than the most serious incident in this case prior to the March 24 hanging attempt, namely, the March 8 self-inflicted wound.

Waldrop is also different from this case in that Waldrop had pled not guilty but mentally ill, had been diagnosed as manic depressive, and placed on lithium, an antidepressant drug, all before coming under the defendant's care. We are satisfied that the defendant- psychiatrist's inadequate response to the symptoms in Waldrop are not comparable to Dr. Jenkins' actions in this case.

In summary, we conclude that the facts adduced by plaintiffs fail to show that Dr. Jenkins' actions[47] were such a departure from professional judgment that a reasonable professional in his shoes would have known that his actions violated David's constitutional rights. Plaintiffs' medical expert's testimony fails to establish the degree of alleged departure. Plaintiffs have not adduced facts to demonstrate that Dr. Jenkins' alleged departure from professional judgment was comparable to that previously found to constitute a violation of constitutional rights.

3. Dr. Maughon

We next address plaintiff's contentions with respect to Dr. Maughon, the other psychiatrist under contract with Eufaula. Dr. Maughon's involvement with David was limited to his initial evaluation of him on January 23, 1992, and his March 21 prescription of Vistaril over the telephone. Evaluating Dr. Maughon's actions in light of the facts then known to him, it is clear that he had less information than Dr. Jenkins, and that his actions are less suspect than those of Dr. Jenkins.

With respect to the initial evaluation, plaintiffs' expert, Dr. Halpern, notes that David had a family history of

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[47]If Dr. Jenkins' actions on March 19, at which point he was privy to several more incidents of David's self-destructive and possibly psychotic behavior, did not violate clearly established constitutional rights, it follows that his alleged failure to take action on March 8 did not violate clearly established constitutional law.

suicide, had made prior suicidal threats and attempts, and suggests *1050 that these were "obvious signs of clinical depression and bipolar disorder." Based on the foregoing, Dr. Halpern concludes that Dr. Maughon "made no attempt to properly evaluate and treat David for these obvious mental disorders." This cursory conclusion does not aid the appellees here. First, Dr. Halpern's conclusion that David should have been evaluated as clinically depressed with bipolar disorder upon being admitted to Eufaula is supported only by the fact that David had made prior suicide attempts and threats and that a family member had committed suicide. Dr. Halpern's affidavit does not set forth any support for his conclusory statement that these factors would have led to the diagnosis he contends is the correct one. Although Dr. Halpern states that Dr. Maughon made "no attempt to properly evaluate and treat David," he does not describe what sort of evaluation should have been conducted. Nor does Dr. Halpern indicate whether or how the prescribed treatment should have been different upon David's admittance had he been correctly diagnosed. Second, there are no indications that Dr. Halpern took into account when David's threats were made.[48] Nor did Dr. Halpern note whether such reports of attempts and threats might have been, absent evidence of injury or near injury, manipulative or attention-getting behavior on David's part as both Jurls' and Dr. Jenkins' notes in David's record seem to imply.[49] Finally, Dr. Halpern's affidavit makes no

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[48]The social history conducted by Jurls simply stated that David had had suicidal thoughts and gestures within the two years before being admitted to Eufaula. His Baldwin County report conducted in August 1991 did indicate that at least one threat occurred in March 1991.

[49]For example, Jurls wrote on March 2 that David continued to enjoy the "shock value" of talking about suicide. The record seems to indicate that Jurls questioned whether David had ever actually at-

effort to evaluate the degree to which Dr. Maughon had allegedly departed from accepted medical standards.

Dr. Maughon's alleged misdiagnosis is less egregious than that of the psychiatrist in Greason and Waldrop. That psychiatrist knew that mental health professionals outside the prison system had previously diagnosed the inmates as suffering from serious psychiatric conditions and that those outside professionals had recommended that the inmates remain on previously prescribed psychiatric medications. Here the only previous diagnosis available to Dr. Maughon was the psychological evaluation from Baldwin County Mental Health Center, and it did not set forth any diagnosis but recommended only that David return to outpatient counseling and be placed in a residential program if his condition deteriorated. The evidence indicates that as of January 1992, when the initial intake was done, no other doctor or psychologist had suggested that David be evaluated for anti-psychotic medication.[50] Nor does Dr. Maughon's behavior appear to be more egregious than that of the physician in *Rogers v. Evans*, 792 F.2d 1052 (11th Cir.1986), where the doctor was potentially liable for having withdrawn medical care in response to the justified criticisms of the inmate's family and where her use of two different medications was called into question.

After the initial assessment completed on January 23, Dr. Maughon was contacted only once more, on Saturday, March 21. At that time, David had been placed in seclusion after destroying property and threatening to

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tempted suicide. She noted in the January 27, 1992, suicide assessment form that David's family had no knowledge of David's past attempts and that David's self- reported gestures could not be confirmed. In the same report she described his suicidal thoughts as without genuine intent.

[50]Dr. Nixon, not a psychiatrist, referred David for evaluation almost two months after Dr. Maughon's initial evaluation of David.

cut himself with a piece of glass. He was beating his head on the wall and cursing loudly. Dr. Maughon was notified by telephone, and prescribed a tranquilizer over the telephone. In evaluating Dr. Maughon's actions under the circumstances the following factors are relevant. There is no evidence that Dr. Maughon reviewed David's record when he was called on the telephone on Saturday, March 21. Thus, we cannot assume that he had the more extensive knowledge which Dr. Jenkins had. Moreover, the incident on March 21 about which Dr. Maughon was consulted was clearly not as serious as the one about which Dr. Jenkins was consulted.[51] Finally, Dr. Maughon, like Dr. Jenkins, could rely on the Eufaula staff to monitor David's progress.

We readily conclude that plaintiffs have failed to show that Dr. Maughon's actions were such a departure from professional judgment that a reasonable professional in his shoes would have known that his actions violated David's constitutional rights. Indeed, the case against Dr. Maughon's is a fortiori less compelling than the case against Dr. Jenkins because Dr. Maughon is charged with less knowledge and because the particular incident which triggered his consultation was less serious than that which triggered Dr. Jenkins' evaluation.

D. Bradley Mazick, Ph.D.

Dr. Mazick, a psychologist, was clinical director of Eufaula during David's time there. The appellees allege that Dr. Mazick failed to exercise professional judgment both as a psychologist involved with David's care and as clinical director of the facility by failing to review David's record, failing to supervise Jurls, failing to reform

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[51]The notes about this incident in David's record indicate only that "Dr. Maughon was notified about this resident beating and banging head on walls and cursing and totally out of control—He said give Vistaril 50 mg in stat . . . . "

Eufaula's seclusion and time out policies, and failing to take measures to prevent the alleged abuse at Eufaula. We will first address whether Dr. Mazick's personal treatment of David violated David's constitutional rights and then address whether Dr. Mazick's alleged failure to discharge his administrative/supervisory duties amounted to constitutional violations.

1. Dr. Mazick's Treatment of David

The appellees generally contended that Dr. Mazick departed from the most basic professional judgment in his treatment of David. They apparently base this allegation on his alleged failure as a general matter to supervise and to ensure for David the necessary and essential psychiatric treatment, and his failure to see David until two months after David was assessed and recognized as having made suicidal threats and gestures.

Dr. Mazick had only two personal contacts with David. The first was shortly after David injured his left wrist. Dr. Mazick secluded him sometime after that incident and asked him about his arm at that point. Then Dr. Mazick saw David briefly on March 24 when he had an informal conversation with him.[52] Plaintiffs have failed to adduce evidence that Dr. Mazick knew that David had attempted to hang himself on March 22. The record indicates that he had not seen the March 22 entry nor did he know that David had attempted to injure himself on March 21.[53]

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[52]In his deposition, Dr. Mazick testified that he saw David in the hallway and that David requested to speak with him.

[53]Mazick noted that David was due to be off close observation status because he had been free of self-injurious behavior for several days. However, had he looked at David's record, he would have realized that there were two self-injurious incidents over the weekend. Apparently, he was inferring that such was the case from David's comments and from Jurls' decision to take David off close observation.

The plaintiffs presented no further evidence from which a fact finder could infer that Dr. Mazick knew of the March 22 hanging attempt. Although the expert affidavit asserts that Dr. Mazick's behavior was not based on professional judgment because he failed to review the record, it is not clear that Dr. Mazick's failure to review the record in this situation rises to the level of unconstitutionality. First, the record does not indicate that Dr. Mazick was involved in the decision to take David off close observation.[54] Second, plaintiffs have not adduced evidence to suggest that Dr. Mazick could not delegate the responsibility to Jurls and McBride to review residents' records and to bring relevant information to his attention. Finally, the affidavit of plaintiffs' expert, upon which plaintiffs apparently rely to show deficient professional supervision, is wholly conclusory and is of little assistance.

We readily conclude that plaintiffs have failed to show that a reasonable professional in Dr. Mazick's shoes would have known that his actions violated David's constitutional rights.

2. Dr. Mazick's supervisory duties

The plaintiffs allege that Dr. Mazick's failure to discharge his supervisory duties violated clearly established constitutional law and bore a causal relationship to David's injury. It is true that in some situations, supervisors may be held liable for failing to train and supervise their subordinates adequately.

> [Supervisory] liability under section 1983 "must be based on something more than a theory of

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[54]He did indicate after the fact that he told David that he saw no reason David should not be taken off close observation, but the record does not show nor do the plaintiffs contend that he took part in that decision.

> respondeat superior. Supervisory liability occurs either when the supervisor personally participates in the alleged constitutional violation or when there is a causal connection between actions of the supervising official and the alleged constitutional deprivation. The causal connection can be established when a history of widespread abuse puts the responsible supervisor on notice of the need to correct the alleged deprivation, and he fails to do so."

Cross v. Alabama Dep't. of Mental Health & Mental Retardation, 49 F.3d 1490, 1508 (11th Cir.1995) (quoting *Brown v. Crawford*, 906 F.2d 667, 671 (11th Cir.1990)); accord *Dean v. Barber*, 951 F.2d 1210, 1215 (11th Cir.1992) ("[A] supervisor may be held liable under section 1983 if the supervisor had personal involvement in the constitutional deprivation or if a sufficient causal connection exists between the supervisor's conduct and the constitutional violation."). A supervisor sued in individual capacity is entitled to qualified immunity unless a reasonable supervisor would have known that his or her actions were unlawful in light of clearly-established law and the information possessed. Greason, 891 F.2d at 836-37.

The plaintiffs allege that Dr. Mazick failed to fulfill his supervisory responsibilities, including his duty to supervise Jurls, his duty to review David's clinical course on a regular basis given the fact that he "had knowledge of David's suicidal condition" and to monitor the amount of treatment David was getting. The expert affidavit of Dr. Hamilton asserts that Dr. Mazick "should have" reviewed David's clinical course on a regular basis and monitored Jurls. However, the expert's affidavit provides no support for his conclusory opinion. Neither the expert's affidavit nor any other evidence adduced by plaintiffs supports their assumption that it was improper for Dr. Mazick to rely on Jurls to bring relevant matters to his attention.

Significantly, Dr. Hamilton does not address the issue of the degree to which Dr. Mazick's actions allegedly departed from accepted professional standards, and thus does not help plaintiffs discharge their heavy burden in that regard. Dr. Hamilton did suggest that in Alabama only psychiatrists and psychologists could diagnose mental illness. However, neither plaintiffs nor their expert indicate why, after a psychiatrist's diagnosis was made, Dr. Mazick could not rely upon Jurls to bring relevant matters to his attention.

None of our case law indicates that a supervisor's failure to monitor an individual patient's progress amounts to deliberate indifference or failure to exercise professional judgment. Thus, even if Dr. Mazick's actions departed in some degree from accepted standards, plaintiffs have failed to carry their burden of establishing such an egregious departure that a reasonable professional in Dr. Mazick's shoes would have known that he violated David's constitutional rights. Dr. Mazick's actions are not as egregious as the actions of Drs. Oliver and Duncan, the medical administrators who were denied qualified immunity in Greason. Both doctors were aware of the severe inadequacies of the institution, including the clearly inadequate number of professional staff. Both knew that the particular psychiatrist assigned to the inmate had an excessive burden. Both were aware that the psychiatrist had discontinued Greason's medication. Both were aware of the previous incident, i.e., the Waldrop incident, in which an inmate had plucked out one of his eyes, severely injured the other eye, and cut his scrotum losing both testicles after the same psychiatrist first discontinued that inmate's psychiatric medication and failed to reinstate one of the medications. See *Waldrop*, 871 F.2d at 1032. Thus, *Greason* does not indicate that Dr. Mazick's conduct violated the Constitution.

Nor are Dr. Mazick's alleged supervisory failures comparable to those in *George v. McIntosh-Wilson*, 582 So.2d

1058 (Ala.1991). In that case a severely mentally retarded patient died when he was left unattended and choked on a rubber glove left within his reach. In that case the court concluded that a fact finder could infer that the administrator failed in her duty to disseminate information to the non-professional direct-care employee regarding the patient's dangerous mouthing habit.

The appellees also assert that Dr. Mazick was responsible for the constitutional violations inherent in Eufaula's seclusion practices, specifically the "inhuman conditions in building 112" as well as the manner in which time out and other forms of restrictions were used. The appellees allege that these practices violated the law set forth in *Romeo*. Their claim fails both factually and legally.

With respect to Building 112, appellees cite no evidence that specifically sets forth that the conditions were inhumane. Although the appellees allege that seclusion in Building 112 had no therapeutic effect, none of the documents they cite support that conclusion. Rather the documents cited by the appellees merely indicate that reforms were necessary with respect to Eufaula's seclusion and restraint system. Nor have appellees presented expert testimony indicating that the restraints used in Building 112 constituted a failure to exercise professional judgment. Their argument with respect to time-out and other forms of restrictions fails for the same reasons.

Appellees claim also fails legally. A conclusory allegation that the use of Building 112's seclusion facility violated *Romeo* is insufficient, absent precedent that more clearly sets forth what form of restraint is violative of *Romeo*. Although *Romeo* stated that the mentally retarded patient in a state institution did have a liberty interest in freedom from bodily restraint, id., 457 U.S. at 316, 102 S.Ct. at 2458, the Court went on to note that that liberty

interest was not absolute. Id. at 319, 102 S.Ct. at 2460. Rather the " 'liberty interest of the individual' " had to be balanced with " 'the demands of organized society.' " Id. Citing *Bell v. Wolfish*, 441 U.S. 520, 540, 99 S.Ct. 1861, 1874, 60 L.Ed.2d 447 (1979), the *Romeo* court indicated that while pre-trial detainees, for instance, could not be punished, restraint of pre-trial detainees "reasonably related to legitimate government objectives and not tantamount to punishment" was upheld. *Romeo*, 457 U.S. at 319, 102 S.Ct. at 2460. The Court further indicated that balancing would be left to the professional judgment of the qualified staff members and that courts need only make certain that professional judgment was exercised. Finally, the Court in *Romeo* never indicated that the restraints used in that case were violative of the patient's due process rights.[55] The appellees have not cited other cases which would indicate that the sort of restraint used here would violate David's right to be free from bodily restraint. Plaintiffs have relied on merely abstract propositions, which the court in *Lassiter v. Alabama A & M University, Board of Trustees*, 28 F.3d 1146, 1150 (11th Cir.1994) (en banc), held was clearly insufficient.

Appellees also allege Dr. Mazick was responsible for not taking remedial actions to halt the beatings and abuse at Eufaula. Eleventh Circuit cases have held that administrators' failure to abate violence and abuse may constitute deliberate indifference. See, e.g., *Hale v. Tallapoosa County*, 50 F.3d 1579 (11th Cir.1995) (where inmate on inmate violence was regular during overcrowding and where it was severe enough to require medical attention and even hospitalization on occasion); *LaMarca v. Turner*, 995 F.2d 1526, 1535 (11th Cir.1993), cert. denied, — U.S. ——, 114 S.Ct. 1189, 127 L.Ed.2d

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[55]In *Romeo*, the patient was physically restrained during portions of each day through the use of soft restraints which apparently bound the arms only.

539 (1994)(where, in a prison context the unnecessary pain and suffering standard is satisfied by "unjustified constant and unreasonable exposure to violence"). However, the evidence presented by the plaintiffs does not indicate that Dr. Mazick was apprised of an extent of violence and abuse which would have put him on notice that his failure to act in the face of such abuse and violence would rise to the level of a constitutional violation.

With respect to the allegations that abuse was rampant at Eufaula, the appellees have presented as evidence the affidavits of John Fowler and Billy Kirby as well as the testimony of Forte. The affidavit of Kirby did allege that Dr. Mazick knew about the beatings. Specifically, Kirby stated that he complained to Dr. Mazick that "all of [the residents] were being hit by staff members including . . . David . . . and lots of others." However, we do not believe that this limited information would support a finding that violence and abuse were so rampant that failure to react would constitute a clearly-established constitutional violation. Plaintiffs also presented as evidence of abuse and violence the FY 1991-92 Advocacy Monitoring Report. That report, for the reasons discussed supra at Part I, did not provide sufficient evidence to indicate that physical abuse was such that a jury could infer that Dr. Mazick knew that the abuse and violence were rampant. The report only concluded that incident investigations were inadequate; it only detailed a few allegations and none had been substantiated.[56] Thus, we do not believe that the case law clearly established that a reasonable

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[56]A jury might infer that Dr. Mazick had learned of the plight of the resident discussed in Forte's affidavit. Forte testified that one resident had to be taken to the hospital twice to be treated for injuries incurred when other residents sexually abused him. However, even assuming Dr. Mazick knew of these two incidents also, the totality of what he knew does not create an inference that the episodes of abuse at Eufaula rose to the level discussed in the text.

professional possessing the knowledge that Dr. Mazick had would have known that his actions violated David's constitutional rights.

E. Anthony Dykes

Anthony Dykes was the director of the Eufaula Adolescent Center. Dykes was not trained in psychology, psychiatry, or social work, thus Dykes was not a mental health professional. Nevertheless, as an administrator or supervisor, he would be liable if he participated in the constitutional violation or if a causal connection existed between his actions and the constitutional deprivation. *Cross v. Alabama Dep't. of Mental Health & Mental Retardation*, 49 F.3d 1490 (11th Cir.1995).

First, appellees contend that Dykes failed to make sure David was free from unnecessary bodily restraints, i.e., that he allowed the practice of restraining patients for punitive rather than therapeutic purposes, and that he allowed the use of Building 112 for seclusion. For the reasons discussed above with respect to Dr. Mazick, this allegation must fail.

Second, appellees allege that Dykes failed to make sure that David did not experience abuse at Eufaula. Although, Kirby's affidavit asserts that he told Dykes of the beatings children received at the hands of staff or other residents, this allegation must fail for the reasons set forth supra in our discussion of this allegation with respect to Dr. Mazick.

Third, appellees contend that Dykes violated David's constitutional rights by failing to make sure conditions at Eufaula were safe, among other things, by failing to remove the bars from the dormitory closets. We first note that Dykes could reasonably rely on subordinates to ensure that a child who was at risk of doing harm to himself would be placed on close or continuous observation or

that other precautionary measures might be taken. More importantly, we find no case law indicating that Dykes violated clearly established constitutional rights.[57] This case is distinguishable from *Greason*; there the non-professional administrator was held liable because he took no corrective action, notwithstanding having been specifically put on notice of particular defects or inadequacies in his facility.[58] Unlike the situation in Greason, no evidence of earlier incidents of injury involving the alleged inadequacy, i.e., the bars in the dormitory closets, was presented.

Fourth, appellees also contend that Dykes failed to make certain that David had adequate medical care, specifically, adequate psychiatric care or adequate individual treatment as would give him the realistic opportunity to be cured or to improve his medical condition. However, there is no indication that Dykes knew the details of David's history of suicidal threats or gestures or that Dykes knew about the specific behaviors David exhibited while at Eufaula. Moreover, appellees' complaints about Dykes in this regard rely on abstractions, which we readily conclude are insufficient. See *Lassiter*, 28 F.3d at 1150.

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[57]In *Belcher v. City of Foley*, 30 F.3d 1390 (11th Cir.1994), this circuit held that it was not clearly established that "a reasonable jail official, who knew that an inmate could hang himself by tying some material to the bars of a jail-cell door and yet who failed to prevent that possibility, was acting with deliberate indifference to an inmate's taking of his life." Id. at 1399.

[58]In that case, Kemp, the warden of the facility where an inmate committed suicide, knew of particular inadequacies in his facility but did nothing to correct them and knew a similar incident had occurred previously but did nothing to investigate that previous incident or prevent it from happening again. *Greason*, 891 F.2d at 839-40.

Fifth, appellees argue that Dykes took no steps to insure that Joint Commission on Accreditation of Health Organizations ("JCAHO"), accreditation was attained as required under the Wyatt Consent Decree as amended and approved in *Wyatt v. Wallis*, 1986 WL 69194, *6 (M.D.Ala.1986). We need not address whether a consent decree can in other circumstances clearly establish the constitutional law,[59] because we hold in this case that neither the Consent Decree nor any other precedent clearly established a constitutional right to JCAHO accreditation. As one of many remedial measures, the Wyatt Consent Decree required the state officials "to make all reasonable efforts to achieve full accreditation of Alabama's mental health facilities by the Joint Commission on the Accreditation of Hospitals. . . . . " Id. That mandate, however, does not mean that lack of accreditation is a per se constitutional violation. Such a proposition would be anomalous, and surely is not clearly-established constitutional law.

Finally, appellees contend that Dykes and his subordinates exhibited such a degree of indifference to the policies and procedures that the staff could not have based their decisions on professional judgments embodied in the policies. See *George v. McIntosh-Wilson*, 582 So.2d 1058, 1063 (Ala.1991) ("[P]olicy-making administrators would be liable for the constitutional deprivations caused by their subordinates if they exhibited such a degree of indifference to compliance with their policies as to demonstrate that they did not base their actual administrative

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[59]See *Clark v. Evans*, 840 F.2d 876, 880 n. 4 (11th Cir.1988); *Williams v. Bennett*, 689 F.2d 1370 (11th Cir.1982), cert. denied, 464 U.S. 932, 104 S.Ct. 335, 78 L.Ed.2d 305 (1983); *Jackson v. Mississippi*, 644 F.2d 1142 (5th Cir. Unit A May 1981). See also *Long v. Norris*, 929 F.2d 1111 (6th Cir.), cert. denied sub nom. *Jones v. Long*, 502 U.S. 863, 112 S.Ct. 187, 116 L.Ed.2d 148 (1991); *Green v. McKaskle*, 788 F.2d 1116 (5th Cir.1986).

decisions or actions on the professional judgments embodied in the policy.") However, neither the appellees' expert affidavit nor other evidence in the record indicates which policies were violated as a result of Dykes' failures.[60] Nor do appellees identify the clearly established constitutional rights implicated by such policies. We readily conclude that appellees have failed to establish that these alleged deficiencies on the part of Dykes violated David's clearly established constitutional rights. *Lassiter*, 28 F.3d at 1150.

F. Emmett Poundstone

Emmett Poundstone was ADMHMR Associate Commissioner for Mental Health. The Eufaula facility was within the scope of Poundstone's responsibility. Poundstone was not a mental health professional. The plaintiffs claim that Poundstone failed to make sure that the Eufaula staff were trained in suicide assessment and in recognizing suicidal tendencies. We readily conclude that this claim has no merit. Where an institution is staffed with health care professionals, including licensed psychologists, psychiatrists and social workers, we know of no cases which indicate that in this circuit the failure of a state-wide administrator to make provisions for such training for the mental health care professionals constitutes a violation of clearly established constitutional rights.[61]

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[60]Although it is alleged that Eufaula's policy was violated when David was admitted in contravention of the policy against admitting actively suicidal patients, it is not alleged that Dykes took part in that decision or that he could be directly implicated in that decision.

[61]In *Greason*, numerous failings combined to persuade the court to deny qualified immunity to Dr. Duncan, who held the state-wide position of Director of Mental Health for the Georgia Department of Corrections. Dr. Duncan was aware of the previous and very similar Waldrop incident, was aware that the same psychiatrist primarily re-

As noted in the margin, the remaining claims by plaintiffs against Poundstone fail for reasons already discussed.[62]

G. Royce King

Royce King was ADMHMR commissioner. He is not a mental health professional. The appellees allege that King and his subordinates exercised such a degree of indifference to compliance with the ADMHMR policies that they did not base their actual administrative decisions on professional judgment. However, the appellees

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sponsible for the Waldrop incident was the only source of psychiatric care for Greason, was aware that he could not adequately treat all of the inmates requiring mental health care, was aware that the particular institution made no provision at all for mental health treatment plans, and in general was aware of the conditions at the institution that constituted grossly inadequate mental health care. Nevertheless, Dr. Duncan failed to take any remedial action. Amongst the claims of Dr. Duncan's deficiencies was a claim superficially similar to, but actually much different from the instant claim—i.e., that Dr. Duncan knew that the institution had no policies or procedures designed to help the nonprofessional prison staff and guards recognize suicidal tendencies and prevent suicide attempts. Not only was that alleged deficiency merely one of a number of more serious deficiencies, the instant claim against Poundstone is not that he knew that Eufaula's provisions for suicide assessment were wholly inadequate, but rather that he merely failed to ensure that there were policies requiring more training. We readily conclude that the *Greason* precedent is wholly inapposite.

[62]FN53. The plaintiffs contend that Poundstone is not entitled to summary judgment because (1) he failed to take measures to stop the beating and abuse at Eufaula, (2) he failed to change the allegedly unconstitutional seclusion and time-out policies, and (3) he failed to ensure that Eufaula acquired JCAHO accreditation. The first and second allegations fail for the reasons set forth in Section IV.D. in our discussion of this claim with respect to Bradley Mazick. The third claim fails for the reasons set forth in Section IV.E. in our discussion of this claim with respect to Anthony Dykes.

do not indicate which particular policies King and his subordinates ignored. Nor do appellees identify the clearly-established constitutional rights implicated by such policies. Thus, we readily conclude that appellees have failed to demonstrate a violation of clearly established constitutional rights. See *Lassiter*, 28 F.3d at 1150. Appellees do make a specific contention about King's deficiencies with respect to the Wyatt Consent Decree, i.e., the failure of Eufaula to acquire JCAHO accreditation. However, this claim fails for the reasons stated in Part IV.E., supra. The appellees also allege that King knew that children were being secluded under improper conditions and failed to take action. For the reasons set forth in Part IV.D., supra, this argument also fails.

V. CONCLUSION

For the foregoing reasons, we affirm the district court's denial of summary judgment as to Karen Jurls, and we reverse the court's denial of summary judgment as to the remaining appellants.

AFFIRMED IN PART and REVERSED IN PART.

EDMONDSON, Circuit Judge, dissenting in part and concurring in the result in part:

A great deal of today's opinion is right. I cannot concur, however, in the decision on Karen Jurls.

In my judgment, when Ms. Jurls in 1992 acted or failed to act, it was not already clearly established as a matter of law that the rights, under the fourteenth amendment's due process clause, of mental patients involuntarily civilly committed to state institutions would always be the same as the rights, under the eighth amendment, of convicts in prisons even if the circumstances were otherwise similar. Therefore, I cannot agree that Ms. Jurls (and every reasonable social worker in her place) would be expected to know that *Greason v. Kemp*, 891 F.2d 829 (11th Cir.1990)—a prison case decided on eighth amendment grounds—clearly established as a matter of law the rules governing her conduct outside of a prison and under the fourteenth amendment.

The difference between a prison and some other kind of institution and the difference between the eighth amendment and the fourteenth amendment's due process clause are enough, at least, to cloud the question. To apply *Greason* outside of a prison is not to follow *Greason*, but to extend it. I do not believe that nonlawyers must foresee such extensions or forfeit their immunity. To me, this practice flies in the face of the idea that qualified immunity protects against personal liability unless the defendant's acts violated clearly established pre-existing law.

I know that the Supreme Court in *Romeo* wrote among other things that persons civilly committed are "entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish." But those words are not the holding of *Romeo*. They explain the Romeo decision

in part: they explain why the "deliberate indifference" standard used for prisons was not adopted for mental institutions. But *Romeo* does not hold that every act that violates the eighth amendment rights of a prisoner will doubtlessly violate the due process rights of those involuntarily civilly committed to state institutions. In my view, this idea is not clearly established as a matter of law now and was not so established in 1992.

I do not say that the Supreme Court's words that I have quoted are totally without significance; they have some value as predictors. But, I do say the words do not establish law, in themselves. And, by the way, this Circuit has also never held that the due process rights of mental patients always, at least, equal the eighth amendment rights of prisoners. Therefore, today's court's heavy reliance on *Greason*—an eighth amendment decision—as the case that in 1992 had already clearly established rights outside of the eighth amendment's prison context seems too shaky. I cannot go along.

For me, *Greason*, in the light of the words I have quoted from Romeo, does suggest that courts might ultimately decide that the law requires mental health workers outside of prisons to follow or to exceed the eighth amendment guidelines. But, in *Lassiter*, we said for precedent to suggest something about the applicable law was just not enough.

We said the "pre-existing law must dictate, that is, truly compel (not just suggest or allow or raise a question about), the conclusion for every like- situated, reasonable government agent that what defendant is doing violates federal law in the circumstances." *Lassiter v. Alabama A & M University, Bd. of Trustees*, 28 F.3d 1146, 1150 (11th Cir.1994) (en banc) (emphasis in the original).

In 1992, *Greason* did not (and in my view, as a matter of law, could not) truly dictate the essential conclusion for Karen Jurls and those like her who were working outside

of prisons. I cannot hold this social worker to a clearer understanding of the law—particularly of the precedential authority of *Greason*—than I have.

I dissent from the result for Karen Jurls, but concur in the result otherwise.